

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 23 49		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)	FIRST			MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR		
LOYAL MELVIN BAKER										9-25-81	7 ¹² PM	
3. SEX	4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	
Male	White			Month Day Year March 21, 1916			65					
7a. BIRTHPLACE (COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Wisconsin	U.S.A.						Frederick County,					
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
Frederick	Frederick Memorial Hospital										Track Supt.	Railroad
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13b. STATE Maryland	13c. COUNTY Frederick	14. CITY OR TOWN Brunswick	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 814 Second Ave.						
14. FATHER'S NAME FIRST MIDDLE LAST												
Arhrtur Baker Marie Filteau												
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT Mrs. Grace E. Baker, 814 Second Ave., Brunswick, Maryland 21716			ADDRESS					
no	395-10-0922											
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>respiratory arrest</i>												
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>4151</i> 3 hr												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>anoxia</i>												
DUE TO, OR AS A CONSEQUENCE OF (c) <i>multiple pulmonary emboli</i> 2 d												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a <i>small cell ca long & bony bone narrow phars</i>												
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>April 1981</i> to <i>9/25 1981</i> . (We) lost saw the deceased alive on <i>7/25 1981</i> and that in (My) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (Did) (Did not) view the body after death.												
22b. SIGNATURE DEGREE <i>[Signature]</i>												
ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												
22c. DATE SIGNED <i>9/25/81</i>												
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. P. Gregory Rausch M.D.</i>												
22e. ADDRESS <i>4 West 7th St., Frederick, Md. 21701</i>												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN COUNTY STATE					
Burial	Oct. 1, 1981			Huron Cemetery			Huron					
24. FUNERAL DIRECTOR Smith Fadale Keeney Basford Funeral Home							25a. DATE REC'D. BY REGISTRAR <i>SEP 29 1981</i>			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		
106 E. Church St., Frederick, Md. 21701												

20 DIFFERENT 6000 6000

different numbers 6000 6000

different 6000 6000 different numbers 6000

different numbers 6000 6000 different numbers 6000

different 6000 6000 6000 6000

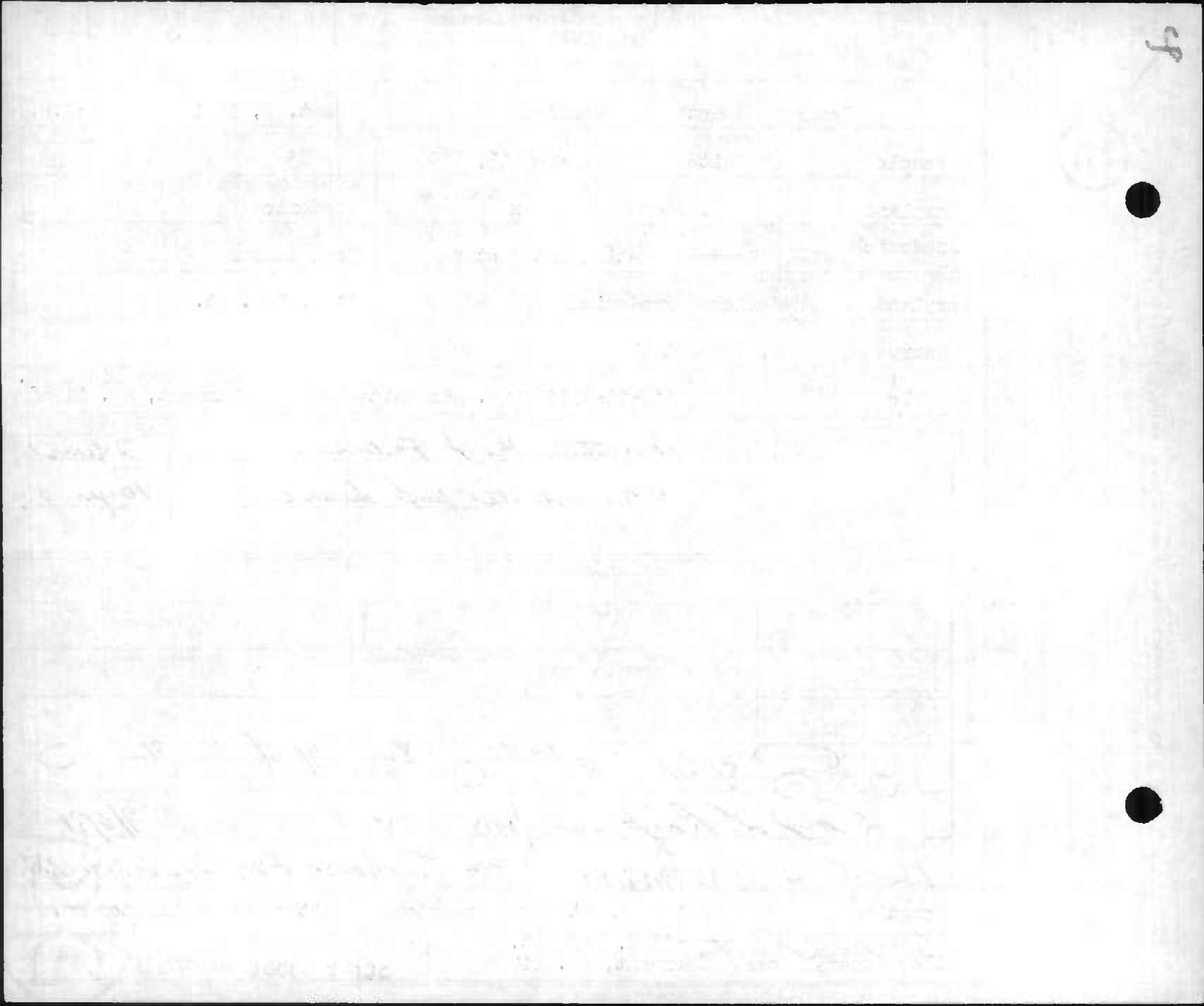


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH						REG. NO. 2 3 4 5 0		
1 - STATE REGISTRAR	FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR
1 DECEASED NAME (TYPE OR PRINT)	Eleanor	Ruth	Barrick	Sept. 5, 1981				5: A.M. M
3 SEX	4 RACE	5 DATE OF BIRTH MONTH DAY YEAR	6 AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN					
Female	White	March 13, 1896	85 YRS					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b CITIZEN OF WHAT COUNTRY? U.S.A.	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9 BALTIMORE CITY OR COUNTY OF DEATH Frederick MD.					
10 CITY OR TOWN OF DEATH Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Homewood Retirement Center	12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Book Keeper	12b. KIND OF BUSINESS OR INDUSTRY Bank					
13a STATE Maryland	13b COUNTY Frederick	13c CITY OR TOWN Frederick	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e STREET ADDRESS 11 W. 3rd. St.				
14 FATHER'S NAME FIRST Harry	MIDDLE W.	LAST Stull	15 MOTHER'S MAIDEN NAME FIRST Reuby	MIDDLE Ogle	LAST			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b SOCIAL SECURITY NO. 219-12-0711	17 INFORMANT Mrs. Margueite Long	ADDRESS 8206 Rocky Ridge Rd. Thurmont, Md. 21788					
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> , 4140 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause first. (b) <i>Arterio sclerotic heart disease</i> (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF <i>10 years</i>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>2 years</i> .		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f LOCATION STREET	CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>1980</i> to <i>9/5/81</i> , that (I) (we) last saw the deceased on <i>8/31/81</i> and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) did not view the body after death.								
22b. SIGNATURE <i>Robert L. Kaufman MD</i> DEGREE <i>MD</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DATE SIGNED <i>9/6/81</i>								
22c. ADDRESS <i>801 Tolchester Ave. Frederick, Md.</i>								
23a BURIAL, CREMATION, REMOVAL Cremation	23b. DATE 9/6/81	23c NAME OF CEMETERY OR CREMATORIAL Smithsburg Crematory	23d LOCATION Smithsburg Washington Md.					
24 FUNERAL DIRECTOR <i>Barley Funeral Home</i>	615 E. Main St. ADDRESS Thurmont, Md. 21788	25a. DATE REC'D. BY REGISTRAR <i>Sept 9 1981</i>	25b. REGISTRAR'S SIGNATURE <i>James C. Smith</i>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	3	9	5	1
1 - STATE REGISTRAR														REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST Amanda AMANDA			MIDDLE Marie MARIE		LAST Bayton BAYTON			2a DATE OF DEATH MONTH DAY YEAR		2b HOUR HOUR MIN.					
3. SEX		4. RACE			5. DATE OF BIRTH 9 TH 2 ND 04			6 AGE (IN YEARS LAST BIRTHDAY) 77 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? USA			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Frederick		MD.							
10 CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Teacher			12b. KIND OF BUSINESS OR INDUSTRY									
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 100 McMurray St.									
14. FATHER'S NAME FIRST George		MIDDLE W.		LAST Penn		15. MOTHER'S MAIDEN NAME Emma		16. SOCIAL SECURITY NO. 220-09-8132		17. INFORMANT Mr. Wm. Lee		ADDRESS Frederick, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 1790 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 1790 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 1790 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 1790 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 1790 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 1790 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a). 1790 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 months			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 13 Sept 81 to 17 Sept 1981, to (we) lost above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED 14 Sept 81					
22b. SIGNATURE Morris A Wilkinson		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Morris A Wilkinson		22e. ADDRESS 707 N. Market St Frederick Md		22f. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/17/81		23c. NAME OF CEMETERY OR CREMATORIUM Fairview Cemetery		23d. LOCATION CITY OR TOWN Frederick		COUNTY Md.									
24. FUNERAL DIRECTOR NAME G. Douglas Stauffer Rt. 10 Fred. Md.				25a. DATE REC'D. BY REGISTRAR SEP 21 1981		25b. REGISTRAR'S SIGNATURE R. Douglas Stauffer											

poste
de la
ville
de
Montreal
au
Ministre
des Postes
et des Telegraphes
du Canada
à Ottawa
le 20 octobre 1908

Montréal, le 20 octobre 1908
Monsieur le Ministre des Postes et des Telegraphes
du Canada
à Ottawa
Le 20 octobre 1908

Monsieur le Ministre des Postes et des Telegraphes
du Canada
à Ottawa
Le 20 octobre 1908

Monsieur le Ministre des Postes et des Telegraphes
du Canada
à Ottawa
Le 20 octobre 1908

Monsieur le Ministre des Postes et des Telegraphes
du Canada
à Ottawa
Le 20 octobre 1908

Monsieur le Ministre des Postes et des Telegraphes
du Canada
à Ottawa
Le 20 octobre 1908

Monsieur le Ministre des Postes et des Telegraphes
du Canada
à Ottawa
Le 20 octobre 1908

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified during the 24-hour period.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE												8	1	2	3	4	5	2
CERTIFICATE OF DEATH												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
Clara Ellen Beck					Beck	September 15, 1981					1981	7 40 AM						
3. SEX			4 RACE	5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR			IF UNDER 24 HRS					
F Female			White	MONTH	DAY	YEAR	73			MONTHS	BAYS	HOURS	MIN.					
7a. BIRTHPLACE (COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH									
Ohio			USA			WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			Frederick									
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY									
Frederick			Frederick Memorial Hospital			Tele. operat.												
13c. STATE			13a. COUNTY	13b. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS										
Maryland			Frederick	Frederick	X			216 E. Church St.										
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			MIDDLE			LAST						
Theodore					Daman	Ellen						Brown						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS									
no			278-20-8109A			Frank McGill			Frederick, Maryland									
18. CAUSE OF DEATH (Enter only one cause per line for part (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Ringing heart.</i>															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 hour.</i>			
4280 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>Chronic long. Heart Disease.</i>															<i>5 years?</i>			
DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE			
22a. I certify that (I) this hospital attended the deceased from Sept. 19, 1981, to 9/15/81, that (I) we last saw the deceased alive on 9/14/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) did (did not) view the body after death.															22c. DATE SIGNED <i>9/15/81</i>			
22b. SIGNATURE <i>Ruth L. Kaysen, MD</i>			22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 9/19/81			23c. NAME OF CEMETERY OR CREMATORIAL St. Augustin's Cem. Napoleon			23d. LOCATION CITY OR TOWN Henry Ohio									
24. FUNERAL DIRECTOR G. Douglas Stauffer Rt. 10 Fred. Md. 2170			25. DATE REC'D. BY REGISTRATION SEP 21 1981															
BP _____																		
DHMH - 16 50M 1/B1 (VRA 15, 4)																		

This image shows a severely overexposed and faded document. The text is completely illegible due to the high brightness. The paper has a yellowish-tinted appearance with visible fibers and some darker spots or stains, characteristic of old, faded paper.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-trust permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	1	2	3	9	5	3		
1 - FOR STATE REGISTRAR										REG. NO.								
1. DECEASED NAME (TYPE OR PRINT)		FIRST Flora			MIDDLE M.	LAST Boward			2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR				
Flora MAY						Boward			9/20/81					12 50 AM				
3. SEX		4 RACE			5. DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS						
Female		White			Month Sept. Day 22 Year 1905			75		YEARS		MONTHS						
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH		MD.								
Penns.		U.S.A.						Frederick Co.										
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY										
Frederick		Frederick Memorial Hospital						Housewife										
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)										13e. STREET ADDRESS		Apt. 53 Sand Spring Court Thurmont, Md.						
Md.		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		Court Thurmont, Md.								
Frederick		Thurmont																
14. FATHER'S NAME		FIRST Clarence	MIDDLE Holtz	LAST			FIRST Blanche	MIDDLE	LAST			Hettinger						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS		8534 Apples Church Rd., Thurmont, Md.								
No		173-03-2638A			Mrs. Paul Fox													
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
IMMEDIATE CAUSE (a) 4100 <i>Cardiorespiratory arrest</i> 30 min.																		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Possible myocard</i> 60 min.																		
DUE TO, OR AS A CONSEQUENCE OF (c) <i>AS CVD</i> ?																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
19b. YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)			21d. LOCATION STREET		CITY OR TOWN		COUNTY		STATE				
21d. WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)																
22a. I certify that (I) (this hospital) attended the deceased from 9/19 19 81 to 9/20 19 81 that (I) (we) last saw the deceased alive on 9/19 19 81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE <i>Robert Edelman</i>										DEGREE MO	ATTENDING PHYSICIAN <input type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 9/20/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Edelman										22e. ADDRESS Frederick Memorial Hospital		Frederick, Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial Sept. 22, 1981			23c. NAME OF CEMETERY OR CREMATORIUM Green Hill Cemetery			23d. LOCATION Waynesboro		CITY OR TOWN		COUNTY		STATE				
24. FUNERAL DIRECTOR NAME <i>David J. Grove</i>		ADDRESS 50 S. Broad St. Waynesboro, Pa.			25a. DATE REC'D. BY REGISTRAR SEP 25 1981			25b. REGISTRAR'S SIGNATURE <i>Frances Jan Hartman</i>										
BP _____																		



12875.932

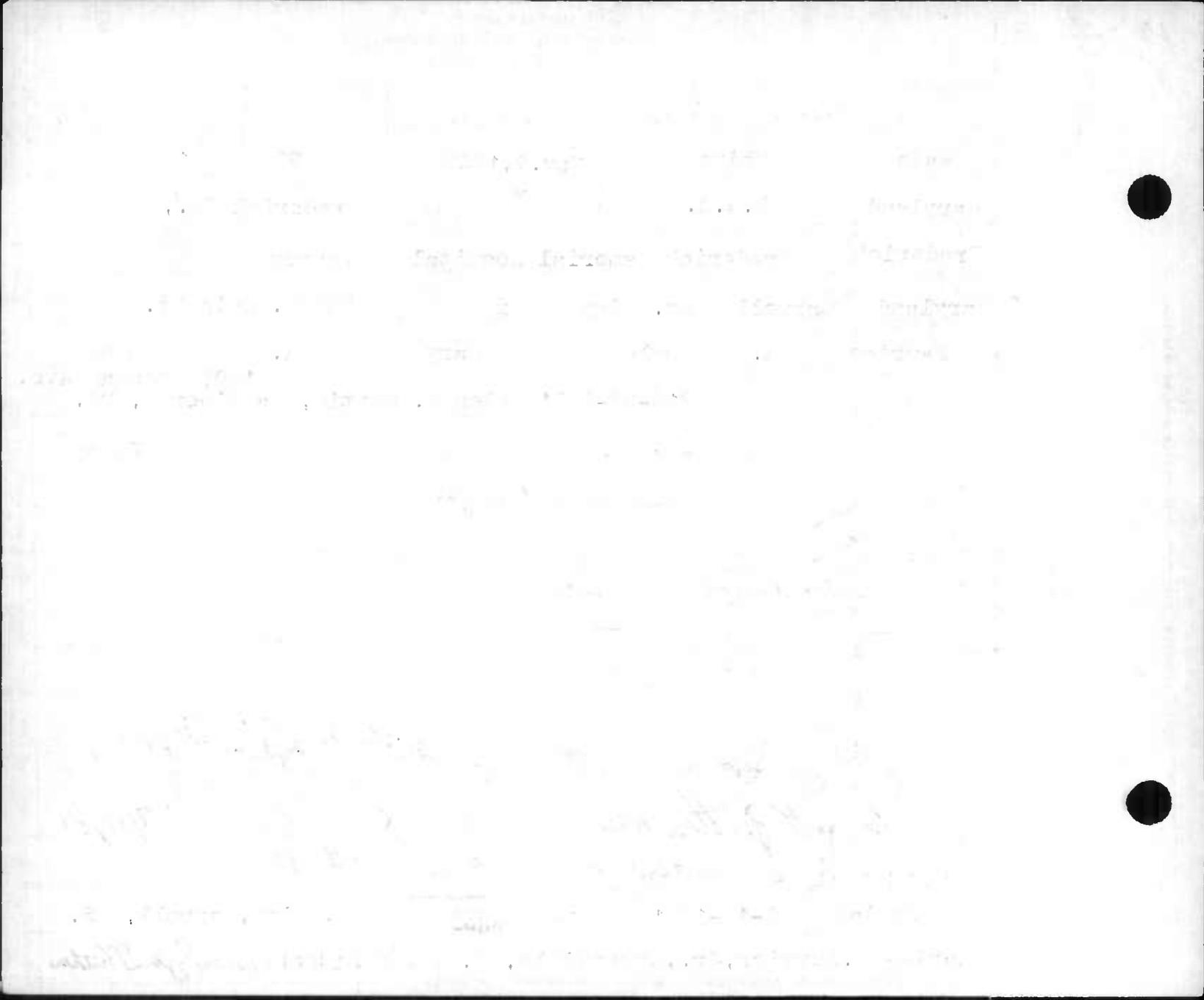
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 1 2 3 9 5 4			
1. DECEASED NAME (TYPE OR PRINT) <i>Luther Pearce Bowlus</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>9 15 81</i>				2b. HOUR <i>2:15 PM</i>			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH Nov. DAY 7 YEAR 1907		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 73		IF UNDER 1 YEAR MONTHS 10		IF UNDER 24 HRS HOURS 8 MIN. 00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick Co., Md.					
10. CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Lawyer		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Maryland		13c. CITY OR TOWN Carroll Mt. Airy		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 404 N. Main St.					
14. FATHER'S NAME FIRST Maurice		MIDDLE A.		LAST Bowlus		15. MOTHER'S MAIDEN NAME FIRST Mary		MIDDLE A.		LAST Young	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-05-8831		17. INFORMANT Helen B. Martin, Baltimore, Md.		ADDRESS 1207 Evesham Ave.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 h.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shock											
1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) abdominal catastrophe DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Colon Cancer - metastasis											
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. — 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) Sept 14 1981		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Sept 11 1981 to Sept 14 1981 , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on above Sept 14 1981 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (I/we) did <input checked="" type="checkbox"/> (did not) view the body after death.											
22b. SIGNATURE <i>Kenneth Zeitzer MD</i>		22c. DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 9/15/81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Kenneth S. Zeitzer MD		22e. ADDRESS 4 West 7th St.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9-18-1981		23c. NAME OF CEMETERY OR BURIAORY Pine Grove		23d. LOCATION CITY OR TOWN Mt. Airy, Carroll, Md.					
24. FUNERAL DIRECTOR Charles W. Burrier, Jr., Sykesville, Md.		25a. DATE REC'D. BY REGISTRAR SEP 18 1981		25b. REGISTRAR'S SIGNATURE <i>Frances Jean Hartman</i>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director [REDACTED] should be detached for use as the burial and Mental Health permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the DSH.

卷之三

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
MARY CATHERINE BOWLUS						9/13/81				12:15 P.M.		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Female		White		Feb. 29 1904			77			IF UNDER 1 YEAR		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		9. DATE OF BIRTH			10. AGE (IN YEARS LAST BIRTHDAY)			11. IF UNDER 24 HRS		
Maryland		U.S.A.					77			MONTHS DAYS HOURS MIN.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Frederick		Frederick Memorial Hospital		Homemaker								
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13b. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS		
Maryland		Frederick		Frederick			NO			1000 Heather Ridge Drive		
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME								
Charles		E. Shepley		Elizabeth						Gaver		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS					
No		220 16 2167		James E. Bowlus, Jefferson, Maryland								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:												
IMMEDIATE CAUSE (a) <u>Carcinoma of pancreas</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Diabetes mellitus</u>												
DUE TO, OR AS A CONSEQUENCE OF (c) _____												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from <u>9/12/81</u> , 1981, to <u>9/13/81</u> , 1981, that (I) (we) last saw the deceased alive on <u>9/12/81</u> , 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (had) (did not) view the body after death.												
22b. SIGNATURE <u>Robert S. Hughes</u>		DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>9/13/81</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert S. Hughes, M.D.		22e. ADDRESS 700 Montclaire Ave, Frederick, Md.										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE <u>9/16/1981</u>		23c. NAME OF CEMETERY OR CREMATORIAL F. Memorial Park			23d. LOCATION CITY OR TOWN		COUNTY STATE			
24. FUNERAL DIRECTOR Smith, Fadley, Keehey & Basford F.H. 106 E. Church Street, Frederick, Md.		ADDRESS		25. DATE REC'D. BY REGISTRAR			26. REGISTRAR'S SIGNATURE <u>SEP 1, 1981</u> <u>Hance</u>					

the following conditions were observed:
1. The water was clear and free from
any suspended matter.
2. The water was at a temperature
of 20° C. or less.
3. The water contained no organic
matter.
4. The water contained no mineral
matter.
5. The water contained no salts.
6. The water contained no gases.
7. The water contained no bacteria.
8. The water contained no viruses.
9. The water contained no fungi.
10. The water contained no protozoa.
11. The water contained no metazoans.
12. The water contained no plants.
13. The water contained no microorganisms.
14. The water contained no macroorganisms.
15. The water contained no organic
matter.
16. The water contained no mineral
matter.
17. The water contained no salts.
18. The water contained no gases.
19. The water contained no bacteria.
20. The water contained no viruses.
21. The water contained no fungi.
22. The water contained no protozoa.
23. The water contained no metazoans.
24. The water contained no plants.
25. The water contained no microorganisms.
26. The water contained no macroorganisms.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-travel permit. Then please remove carbon copy. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called and advised.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 81 23956					
1 - STATE REGISTRAR			FIRST			MIDDLE			LAST			2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)			Hallie			May			BRANDT			September 4, 1981				4:30 P.M.	
3. SEX			4 RACE			White			5. DATE OF BIRTH			Aug. 9, 1888				6. AGE (IN YEARS LAST BIRTHDAY)	
Female									MONTH DAY YEAR							IF UNDER 1 YEAR	
																IF UNDER 24 HRS	
																MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				Frederick County, MD.	
Maryland			U.S.A.														
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			Frederick Memorial Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			Homemaker				12b. KIND OF BUSINESS OR INDUSTRY	
Frederick																Home	
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS					
Maryland			Frederick			Frederick			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			3565 Urbana Pike					
14. FATHER'S NAME			FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME			LAST								
John Henry Boyer						Johanna			Betty							Scheel	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS			3565 Urbana Pike				Frederick, Md. 21701	
No			None			214-10-1128			Mrs. Marion Lawson,								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a):															APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH commits		
1531 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.															multiple abdominal metastases Cancer causes transverse colon		
(b):															3 years		
{ DUE TO, OR AS A CONSEQUENCE OF (c):																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from March 1, 1981, to Sept. 4, 1981, that (I) (we) last saw the deceased alive on Sept. 4, 1981, and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.																	
22b. SIGNATURE			MD			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			Dr. B. O. Thomas, JR., M.D.			22e. ADDRESS			Professional Building, Frederick, Md. 21701			9/8/81					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY			STATE		
Burial			Sept. 5, 1981			Mt. Olivet Cemetery			Frederick, Frederick, Md.								
24. FUNERAL DIRECTOR			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE											
Smith, Fadley, Keeney, Basford Funeral Home 106 East Church St., Frederick, Md. 21701																	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificat has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 23957											
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR 9 15 81									2b HOUR 1 PM											
1. DECEASED NAME (TYPE OR PRINT) FRANKLIN FIRST Quentin MIDDLE Brauner LAST BRAUNER			3. SEX MALE			4. RACE WHITE			5. DATE OF BIRTH MONTH 9 DAY 23 YEAR 97			6. AGE (IN YEARS LAST BIRTHDAY) 83			IF UNDER 1 YEAR MONTHS 0 DAYS 0 HOURS 0 MIN.								
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) TEXAS			7b CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH FREDERICK COUNTY			10. CITY OR TOWN OF DEATH FREDERICK			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) FREDERICK MEM. HOSP.			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MANAGER* RTD.			12b. KIND OF BUSINESS OR INDUSTRY REFUSE CO.		
13a. STATE MD.			13b. COUNTY FREDERICK			13c. CITY OR TOWN THURMONT			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 11035 OLD FREDERICK RD.											
14. FATHER'S NAME FIRST GUS MIDDLE LAST BRAUNER			15. MOTHER'S MAIDEN NAME LENA																				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. 466-10-5140			17. INFORMANT MRS. E. BLANCHE BRAUNER SAME AS # 13			ADDRESS						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 min								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Caducal arrest 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) metastatic CT lung (c) 																							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?											
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET 75 CITY OR TOWN 9/15 COUNTY 81 STATE																	
22a. I certify that (I) (this hospital) attended the deceased from 9/14 to 9/15 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.																							
22b. SIGNATURE: Hawley J. Hickey MD			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9-15-81														
22e. ADDRESS 516 TRAIL FRED. MD.																							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 9-17-81			23c. NAME OF CEMETERY OR CREMATORIAL PARKLAWN CEM.			23d. LOCATION CITY OR TOWN ROCKVILLE COUNTY MONTG. STATE MD.														
24. FUNERAL DIRECTOR NAME JOS. GAWLER'S SONS ADDRESS 5130 WISC.AVE.NW. WASH., D.C.									25a. DATE REC'D. BY REGISTRAR SEP 18 1981			25b. REGISTRAR'S SIGNATURE James Jan Nathan											
DHRH-16 30M 2/80 (VRA 15, 4)																							

1970-1971
1971-1972
1972-1973

e
x

1973-1974
1974-1975
1975-1976

1976-1977
1977-1978
1978-1979

1979-1980
1980-1981
1981-1982

1982-1983
1983-1984
1984-1985

1985-1986
1986-1987
1987-1988

1988-1989
1989-1990
1990-1991

1991-1992
1992-1993
1993-1994

1994-1995
1995-1996
1996-1997

1997-1998
1998-1999
1999-2000

2000-2001
2001-2002
2002-2003

2003-2004
2004-2005
2005-2006

2006-2007
2007-2008
2008-2009

2009-2010
2010-2011
2011-2012

2012-2013
2013-2014
2014-2015

2015-2016
2016-2017
2017-2018

2018-2019
2019-2020
2020-2021

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, then please remove carbon paper. Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

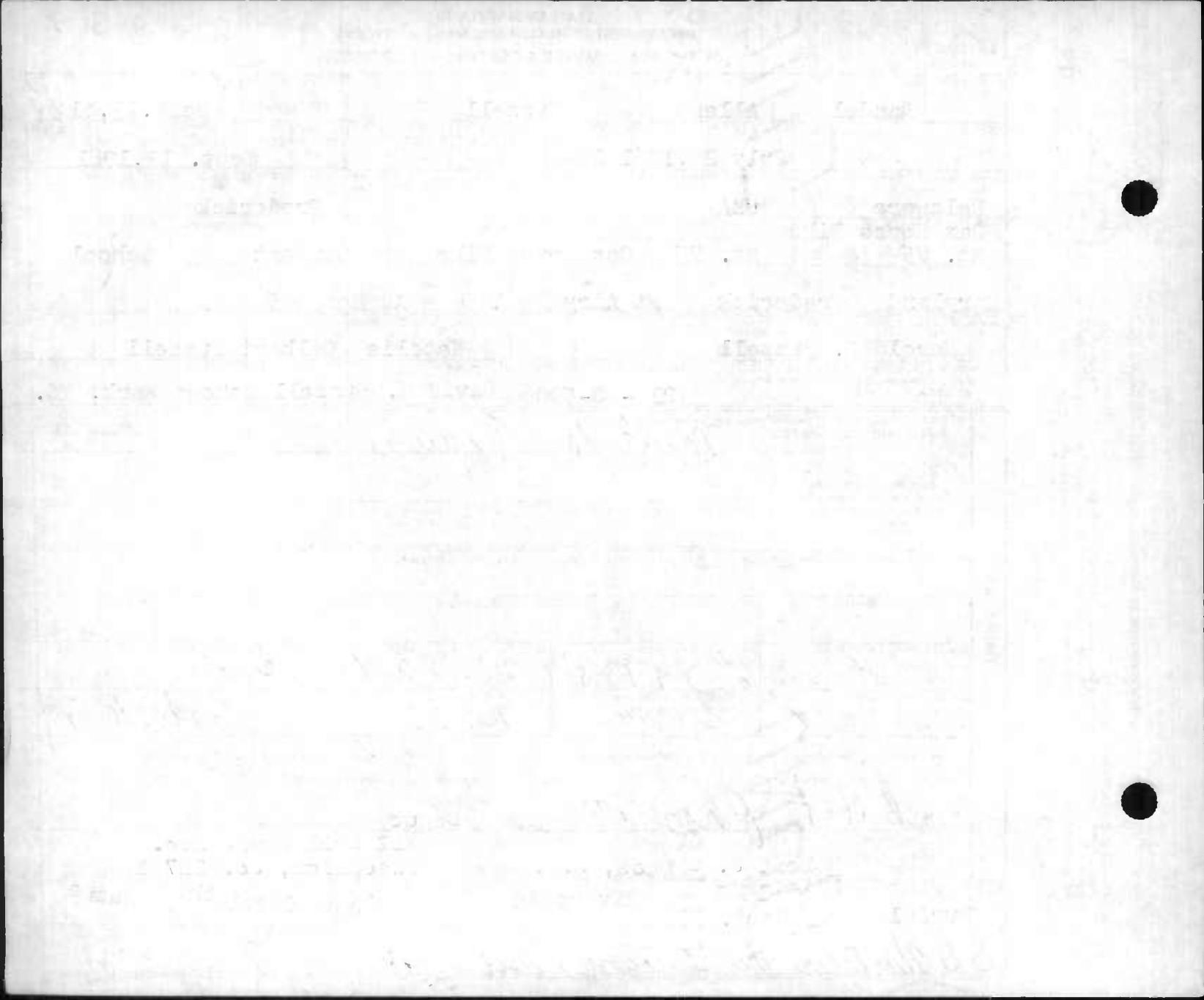
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	2	3	9	5	6
												REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR						
<i>GEORGE Ralph BRIGGS</i>						<i>9-7-81</i>						<i>3⁰⁰ P.M.</i>						
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS						
Male		White		Month Day Year <i>Feb. 22, 1912</i>			69			MONTHS DAYS		HOURS MIN.						
7b. COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.								
Maryland		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			<i>Frederick Co.</i>											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						
Frederick		<i>Frederick Memorial Hospital</i>										Farmer						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS								
Maryland		Montgomery		Damascus						10504 Moxley Rd.								
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST								
		William		Briggs				Mae	E.	Phebus								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
No		709-12-4939		<i>Mary H. Briggs, Item 13</i>														
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)																		
<i>CARDIAC ARREST</i>																		
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												DUE TO, OR AS A CONSEQUENCE OF (b) <i>CHRONIC MYOCARDIAL ISCHEMIA</i>						
												DUE TO, OR AS A CONSEQUENCE OF (c) <i>REPEATED MYOCARDIAL INFARCTIONS</i>						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).																		
Anatomical specimen(s) sent to the medical examiner.		19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
9/9																		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART I OR PART 2)													
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE						
22a. I certify that (1) (this hospital) attended the deceased from <i>1962</i> , 19, to <i>Sept. 7</i> , 19, that (we) last saw the deceased alive on <i>Sept. 7</i> , 19, and that in (my) our opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death.																		
22b. SIGNATURE					DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED								
<i>GILLEN F. MEADORS JR MD</i>										<i>9/7/81</i>								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					<i>MD. 2122</i>								
<i>GILLEN F. MEADORS JR MD</i>					<i>810 Toll House Ave Frederick</i>													
23a. BURIAL, CREMATION, REMOVAL (SPECIES)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE						
Burial		Sept. 10, 1981		Montgomery Meth.			Damascus			Montgomery		Md.						
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. DATE REC'D. BY REGISTRAR			SIGNATURE							
<i>Olin L. Molesworth, P.A., Damascus, Md.</i>								<i>SEP 14 1981</i>			<i>James J. Martin</i>							

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY OCCURS, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3 RETAIN PAGE 3 FOR YOUR FILES.

AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												23959		
												REG. NO.		
1- STATE REGISTRAR		I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE KNOWN OF ESTI- DEATH MATED				MONTH DAY YEAR	2b. HOUR	
		Randel Allan Buzzell						<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Sept. 13, 1981	609		
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YR. MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD	
M		W		July 28, 1961 20 yrs.									Sept. 13, 1981	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED			9. NEVER MARRIED DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH			
Delaware		USA			<input type="checkbox"/>			<input type="checkbox"/>			Frederick			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY						
Gas House Pike Rt. 75 &		Rt. 75 & Gas House Pike			Student			School						
13a. STATE		13b. COUNTY		13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS					
Maryland		Frederick		Mt Airy			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Box 345					
14. FATHER'S NAME FIRST		MIDDLE		LAST			15. MOTHER'S MAIDEN NAME FIRST		MIDDLE			LAST		
Harold O. Buzzell							Natalie Gilbert Buzzell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			16c. INFORMANT		17. ADDRESS		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No		216-80-5908			David H. Buzzell		Tokoma Park, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Multipe Trauma</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause lost</u> . (b) DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)														
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?									
					<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 6 09 13 81			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <i>2 car auto - driver</i>									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <i>Brown</i>			21f. LOCATION STREET <i>RT 75</i> CITY OR TOWN <i>Frederick Md</i> COUNTY STATE									
22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <i>Robert J. Thomas, M.D.</i>														
EXAMINER'S NAME (TYPE OR PRINT)		EXAMINER'S ADDRESS			TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER 812 Toll House Ave. Frederick, Md. 21701									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 1981 Sept. 17			23c. NAME OF CEMETERY OR CREMATORIAL Riverside			23d. LOCATION CITY OR TOWN <i>Cape Elizabeth</i> COUNTY <i>th</i> Maine STATE						
24. FUNERAL DIRECTOR NAME		ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP 16 1981 25b. REGISTRAR'S SIGNATURE <i>James J. Hartzer</i>									
DD Hartzer		Libertytown, Md												

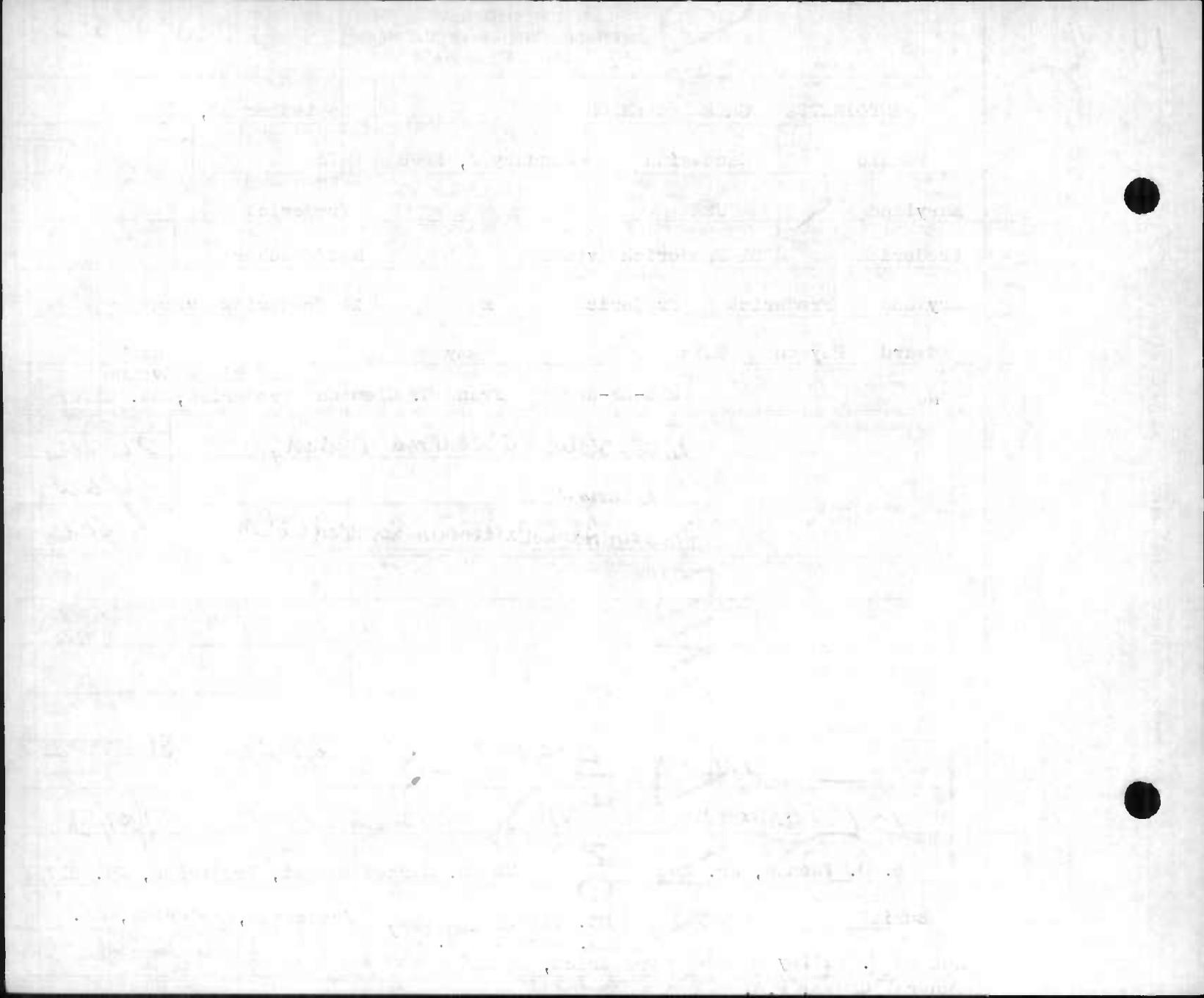


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rehanded by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.											
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR											
I. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	September 28, 1981															
ANTOINETTE GALE CLEMSON																					
3. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS								
Female		Caucasian		January 7, 1906			75				YRS		MONTHS DAYS HOURS MIN								
7a BIRTHPLACE STATE OR FOREIGN COUNTRY		7b CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH										
Maryland		USA									Frederick MD.										
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b KIND OF BUSINESS OR INDUSTRY								
Frederick		21 Frederick Avenue							Ret/Teacher												
13a. STATE Maryland										13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21 Frederick Avenue					
14. FATHER'S NAME FIRST Edward PAYSON MIDDLE Gale LAST										15. MOTHER'S MAIDEN NAME Amy		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 212-38-8680		17. INFORMANT Frank G. Clemson			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										417 Biggs Avenue Frederick, Md. 21701											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART II. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
1533 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost										2 weeks											
(b) Lung										3 years											
(c) Primary AdenoCarcinoma Sigmoid Colon										5 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET				CITY OR TOWN		COUNTY	STATE								
22a. I certify that (1) (this hospital) attended the deceased from <u>March 2, 1981</u> to <u>Sept. 28, 1981</u> , that (1) <u>was</u> last saw the deceased alive on <u>Sept. 27, 1981</u> , and that in (my) <u>opinion</u> death occurred on the date and hour and from the causes stated above, (1) <u>did not</u> view the body after death.																					
22b. SIGNATURE <u>B. O. Thomas Jr.</u>										DEGREE <u>M.D.</u>	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED <u>9/29/81</u>									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>B. O. Thomas, Jr. MD</u>										22e. ADDRESS <u>228 N. Market Street, Frederick, Md. 21701</u>											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE <u>9/30/81</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Mt. Olivet Cemetery</u>			23d. LOCATION CITY OR TOWN <u>Frederick, Frederick, Md.</u>		COUNTY	STATE									
24. FUNERAL DIRECTOR NAME <u>Robert E. Dailey & Son</u>			ADDRESS <u>1201 N. Market St.</u>			25. DATE REC'D. BY REGISTRAR <u>OCT 1 1981</u>			25. REGISTRAR'S SIGNATURE <u>Home J. Dailey</u>												

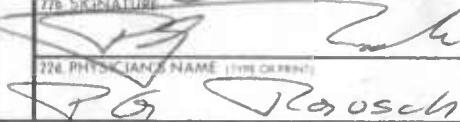


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

I

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 23 61		
										REG. NO.		
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR		
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		9 - 28 - 81		7:20P M	
Raymond Odell Coates												
3. SEX M			4. RACE BLACK			5. DATE OF BIRTH MONTH DAY YEAR APR 24 1929			6. AGE (IN YEARS LAST BIRTHDAY) 52		IF UNDER 1 YEAR MONTHS DAYS YRS	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD			7b CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH FREDERICK MD		IF UNDER 24 HRS HOURS MIN.	
10. CITY OR TOWN OF DEATH FREDERICK			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) MEMORIAL HOSPITAL			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER			12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION			
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) IN STATE D.C. IN COUNTY —			13c. CITY OR TOWN WASHINGTON			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 1361 HAMILTON			
14. FATHER'S NAME FIRST CHARLES MIDDLE H LAST COATES			15. MOTHER'S MAIDEN NAME FIRST IDA MIDDLE COATES LAST FISHER			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b SOCIAL SECURITY NO. 215-20-9032			
16c. INFORMANT MRS JOANN BROOKS NEW WINDSOR MD			17. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
18. CAUSE OF DEATH (Enter only one cause per line for 1a), (b) and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) respiratory arrest												
1619 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			DUE TO, OR AS A CONSEQUENCE OF (b) extensive squamous cell									
			DUE TO, OR AS A CONSEQUENCE OF (c) cancer liver + lung						6 mo			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a												
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED						20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____						
22a. I certify that (I) (this hospital) attended the deceased from 8/12 , 19 81 , to 9/28 , 19 81 , that (I) (we) last saw the deceased alive on 9/28 , 19 81 , and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) (Did) (Did not) view the body after death.												
22b. SIGNATURE 			22c. DEGREE MD			22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22e. DATE SIGNED 9/28/81			
22f. PHYSICIAN'S NAME (TYPE OR PRINT) J. P. Rosenthal			22g. ADDRESS 4 west Scotty									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE OCT 3-1981			23c. NAME OF CEMETERY OR CREMATORIAL WESLEY			23d. LOCATION CITY OR TOWN LIBERTYTOWN COUNTY MARYLAND STATE MD			
24. FUNERAL DIRECTOR NAME DD Hartzler Libertytown Md			25a. DATE REC'D. BY REGISTRAR OCT 1 1981			25b. REGISTRAR'S SIGNATURE Thomas J. Rosenthal						

1960. 10. 20. 10. 20. 10. 20.

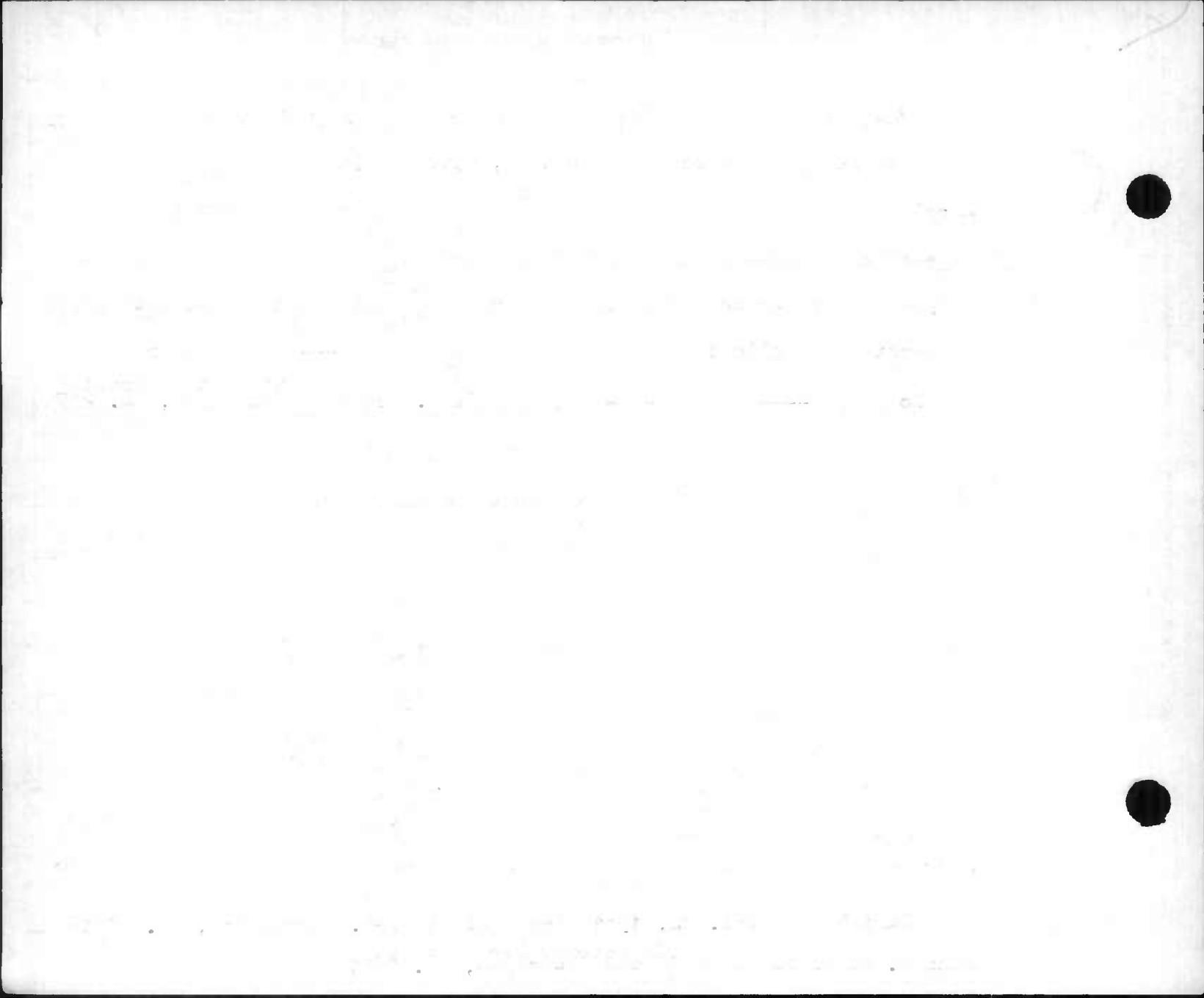
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be relocked for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 1 2 3 9 6 2
REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>MARIE</i>	MIDDLE <i>Hester</i>	LAST <i>Conner</i>
2a. DATE OF DEATH		MONTH <i>9</i>	DAY <i>19</i>	YEAR <i>1981</i>
2b. HOUR		<i>6:05 AM</i>		
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR <i>June 18, 1910</i>	
Female		White	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>	8.	
10. CITY OR TOWN OF DEATH <i>Frederick</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Frederick Memorial Hospital</i>	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Homemaker</i>	
13a. STATE <i>Maryland</i>		13b. COUNTY <i>Frederick</i>	13c. CITY OR TOWN <i>Brunswick</i>	
14. FATHER'S NAME FIRST <i>Ernest</i>		MIDDLE <i>Elliott</i>	LAST <i>Myers</i>	
15. MOTHER'S MAIDEN NAME FIRST <i>Emma</i>		MIDDLE ---	LAST <i>Barger</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ---	17. INFORMANT <i>Willie M. Conner</i>	
			ADDRESS <i>11 West E Street Brunswick, Md. 21716</i>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
<i>1539</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		<i>CARDIORESPIRATORY ARREST</i>		
{ (b) <i>RECURRENT MASSIVE PULMONARY EMBOLISM</i>		DUE TO, OR AS A CONSEQUENCE OF <i>TERMINAL COLON CANCER</i> 1981		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>ENTERIC FISTULA</i>				
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on <i>9-18-81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did/did not view the body after death.		22b. DEGREE	CITY COUNTY STATE	
22c. SIGNATURE <i>A. Mansfield, M.D.</i>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED <i>9/19/81</i>	
22e. ADDRESS <i>GREEN VALLEY, monrovia, md 21770</i>				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>Sept. 22, 1981</i>	23c. NAME OF CEMETERY OR CREMATORIAL <i>Park Heights Cem.</i>	23d. LOCATION CITY OR TOWN <i>Brunswick, Md. 21716</i>
24. FUNERAL DIRECTOR NAME <i>John T. Williams Funeral Home</i>		25a. DATE REC'D. BY REGISTRAR <i>100 Petersville Road</i>	25b. REGISTRAR'S SIGNATURE <i>SEP 23 1981</i>	

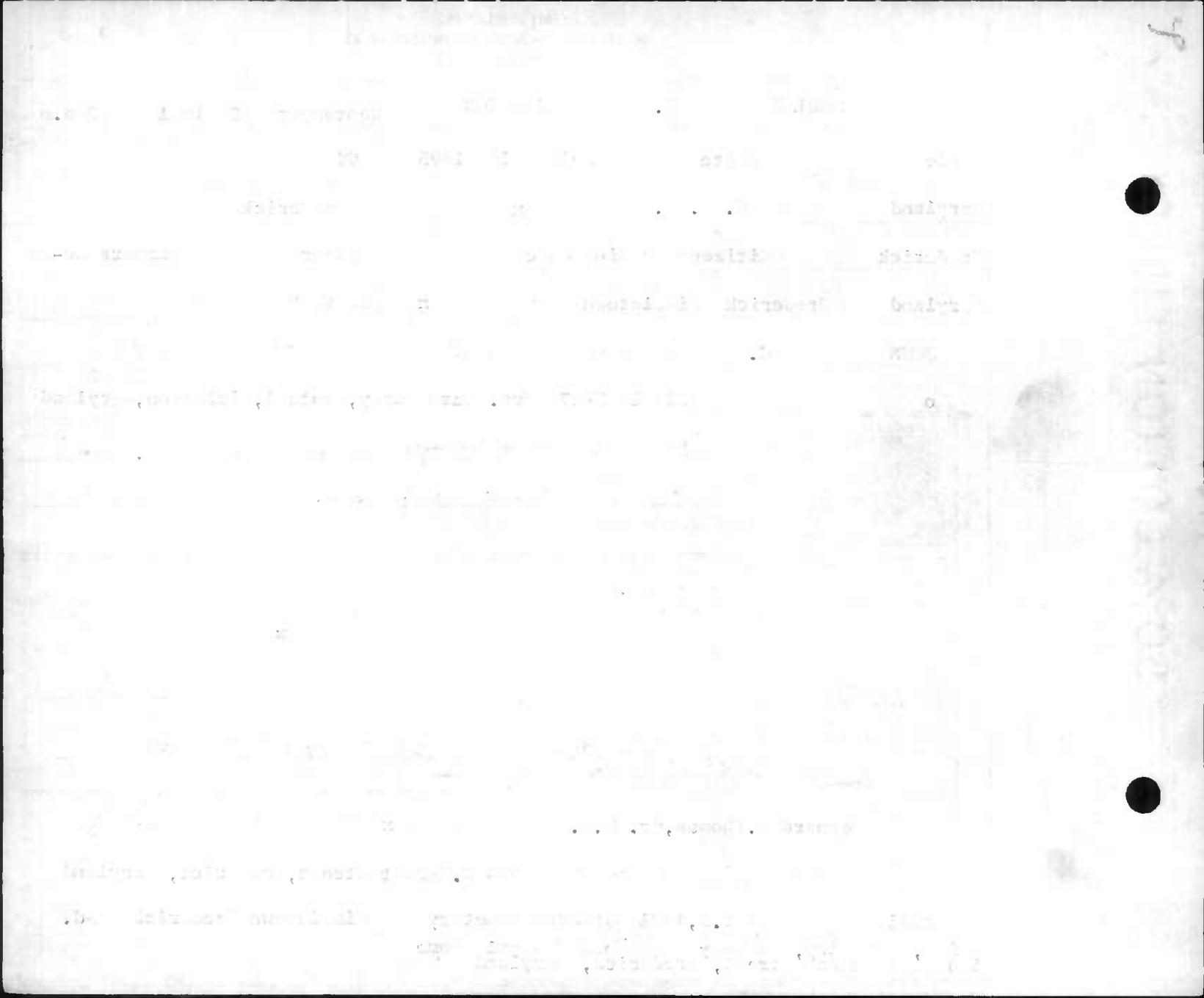


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												3 1 2 3 9 6 3			
												REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
CHARLES F. CRAMPTON						September			2	1981		2 a.m M			
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		July 16 1893			88			MONTHS	YEARS	MONTHS	DAYS	HOURS	MIN.
BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Maryland		U. S. A.						Frederick							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Frederick		Citizens Nursing Home			Helper			Farmers Co-op							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
Maryland		Frederick		Middletown					Route 2						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS	
		JOHN	C.	CRAMPTON	EMMA			216 14 5647			Mrs. Ruth Barry, Route 1, Dickerson, Maryland			20842	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART I. DEATH WAS CAUSED BY:		10 minutes													
IMMEDIATE CAUSE (a)		Cerebral hemorrhage													
4310		15 years													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) Cerebral arterio-sclerosis													
		DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
							YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) (this hospital) attended the deceased from Sept. 1, 1981, to Sept. 2, 1981, that (I) <input type="checkbox"/> last saw the deceased alive on Sept. 1, 1981, and that in (my) <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.															
22b. SIGNATURE		Bernard O. Thomas, Jr. M.D.			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		Bernard O. Thomas, Jr. M.D.			22e. ADDRESS						9/2/81				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY		STATE			
Burial		Sept. 5, 1981		Lutheran Cemetery			Middletown			Frederick		Md.			
24. FUNERAL DIRECTOR		Smith, Fadley, Keeney & Basford Funeral Home			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRABLE SIGNATURE							
		106 East Church Street, Frederick, Maryland			SEP 3 1981			John J. Morris							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director it should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours along with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 2 3 9 6 4									
										REG. NO.									
1 - FOR STATE REGISTRAR		2a DATE OF DEATH MONTH DAY YEAR								2b HOUR									
		September 7, 1981								10: A.M.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		3. SEX		4 RACE		5 DATE OF BIRTH MONTH DAY YEAR		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
Mary E. DAVIS								Female		White		Jan. 3, 1895		86					
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH													
Maryland		U.S.A.				Frederick County, MD.													
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)								12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY							
Adamstown		5117 Doubs Road								Homemaker		Home							
13a STATE Maryland		13b COUNTY Frederick		13c CITY OR TOWN Adamstown		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 5117 Doubs Road											
14. FATHER'S NAME First Samuel		Middle Edward		Last Stup		15. MOTHER'S MAIDEN NAME First Adessa													
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO None		16c PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		17 INFORMANT Miss Helen L. Davis, Adamstown, Md. 21710		ADDRESS 5117 Doubs Road											
No		705-07-1614		4295 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		DUE TO, OR AS A CONSEQUENCE OF (b) CVI		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days											
				DUE TO, OR AS A CONSEQUENCE OF (c) Previous elevation CVI Dec 15-9-81				2 weeks											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																			
Health history large																			
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED								20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET		CITY OR TOWN		COUNTY		STATE									
22a I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 9/6/1981 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										22b DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c DATE SIGNED 9/6/81							
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. A. T. Brice, M.D.		22e ADDRESS Jefferson, Maryland																	
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE Sept 10, 1981		23c NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		23d LOCATION CITY OR TOWN Frederick, Frederick, Md.		COUNTY		STATE									
24 FUNERAL DIRECTOR Smith, Wadeley, Keeney Basford Funeral Home 106 E. Church St., Frederick, Md. 21701		25 DATE REC'D. BY REGISTRAR SEP 15 1981								26 REGISTRATION NUMBER									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	1	2	3	4	6	5
										REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)										2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
<i>Sister Bernadette Fey</i>										Sept. 20, 1981				9:45 a.m.		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)				IF UNDER 1 YEAR		IF UNDER 24 HRS				
Female		White		JUNE 26, 1902		79				YRS.		MONTHS DAYS HOURS MIN				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8.		MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
New York		U.S.A.								Frederick						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Emmitsburg		Villa St. Michael, Emmitsburg, Md.										Teacher		Dgtrs. of Charit		
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME				
Md.		Frederick		Emmitsburg				333 S. Seton Avenue		Louis A. Fey		Mary Ann Urts				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS										
No		230-70-2234T		Sr. Josephine-Villa St. Michael Emmitsburg												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
IMMEDIATE CAUSE (a) <i>Cerebrovascular Accident</i>												7 days				
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cerebrovascular Insufficiency</i>				
{ DUE TO, OR AS A CONSEQUENCE OF (c)												years				
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)																
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I/we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>Alan Carroll M.D.</i>		22c. DATE SIGNED 20 Sept. 81		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>												
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		S. Seton Ave. Emmitsburg, Md. 21727												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION CITY OR TOWN		COUNTY		STATE						
Burial		22 Sept. 81		St. Joseph's		Emmitsburg		Frederick		Md.						
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE										
Skiles Funeral Home		Emmitsburg, Md. 21727		SEP 23 1981		<i>Skiles</i>										

Year	Copy 19	Copy 20	Copy 21	Copy 22
19	1991, Jan 20	X	1991, Jan 20	1991, Jan 20
20	X			
21			X	
22				X
23				
24				
25				
26				
27				
28				
29				
30				
31				
32				
33				
34				
35				
36				
37				
38				
39				
40				
41				
42				
43				
44				
45				
46				
47				
48				
49				
50				
51				
52				
53				
54				
55				
56				
57				
58				
59				
60				
61				
62				
63				
64				
65				
66				
67				
68				
69				
70				
71				
72				
73				
74				
75				
76				
77				
78				
79				
80				
81				
82				
83				
84				
85				
86				
87				
88				
89				
90				
91				
92				
93				
94				
95				
96				
97				
98				
99				
100				
101				
102				
103				
104				
105				
106				
107				
108				
109				
110				
111				
112				
113				
114				
115				
116				
117				
118				
119				
120				
121				
122				
123				
124				
125				
126				
127				
128				
129				
130				
131				
132				
133				
134				
135				
136				
137				
138				
139				
140				
141				
142				
143				
144				
145				
146				
147				
148				
149				
150				
151				
152				
153				
154				
155				
156				
157				
158				
159				
160				
161				
162				
163				
164				
165				
166				
167				
168				
169				
170				
171				
172				
173				
174				
175				
176				
177				
178				
179				
180				
181				
182				
183				
184				
185				
186				
187				
188				
189				
190				
191				
192				
193				
194				
195				
196				
197				
198				
199				
200				
201				
202				
203				
204				
205				
206				
207				
208				
209				
210				
211				
212				
213				
214				
215				
216				
217				
218				
219				
220				
221				
222				
223				
224				
225				
226				
227				
228				
229				
230				
231				
232				
233				
234				
235				
236				
237				
238				
239				
240				
241				
242				
243				
244				
245				
246				
247				
248				
249				
250				
251				
252				
253				
254				
255				
256				
257				
258				
259				
260				
261				
262				
263				
264				
265				
266				
267				
268				
269				
270				
271				
272				
273				
274				
275				
276				
277				
278				
279				
280				
281				
282				
283				
284				
285				
286				
287				
288				
289				
290				
291				
292				
293				
294				
295				
296				
297				
298				
299				
300				
301				
302				
303				
304				
305				
306				
307				
308				
309				
310				
311				
312				
313				
314				
315				
316				
317				
318				
319				
320				
321				
322				
323				
324				
325				
326				
327				
328				
329				
330				
331				
332				
333				
334				
335				
336				
337				
338				
339				
340				
341				
342				
343				
344				
345				
346				
347				
348				
349				
350				
351				
352				
353				
354				
355				
356				
357				
358				
359				
360				
361				
362				
363				
364				
365				
366				
367				
368				
369				
370				
371				
372				
373				
374				
375				
376				
377				
378				
379				
380				
381				
382				
383				
384				
385				
386				
387				
388				
389				
390				
391				
392				
393				
394				
395				
396				
397				
398				
399				
400				
401				
402				
403				
404				
405				
406				
407				
408				
409				
410				
411				
412				
413				
414				
415				
416				
417				
418				
419				
420				
421				
422				
423				
424				
425				
426				
427				
428				
429				
430				
431				
432				
433				
434				
435				
436				
437				
438				
439				
440				
441				
442				
443				
444				
445				
446				
447				
448				
449				
450				
451				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be consulted.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												81 23965
												REG. NO.
1 - FOR STATE REGISTRAR			2a DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	September 26, 1981			a.m.			
Mollie I. FILBY												
3. SEX			4 RACE			5 DATE OF BIRTH			6 AGE (IN YEARS LAST BIRTHDAY)			
Female			White			May 18 1881			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH			
Maryland			U.S.A.						Frederick County, MD.			
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
Frederick			Homewood Retirement Center			Cook			Restaurants			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)												
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS				
Maryland		Frederick		Frederick				426½ North Market Street				
14. FATHER'S NAME FIRST			MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			LAST				
James			W.	Linton	Clara			Nusz				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS			
no			212-12-4197			Mrs. Gertrude Willard, 316 West College Terrace, Frederick, Md.						
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH												
II CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pneumonia</u> 4860 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)												
DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Coronary Artery Disease												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>many years</u> 19, to <u>9/26/81</u> 19, that (I) (we) last saw the deceased alive on <u>9/25/81</u> 19, and that (I) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (I) (did not) view the body after death.												
22b. SIGNATURE <u>Austin Pearre</u>			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/29/81			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. A. Austin Pearre, Jr.			22e. ADDRESS 804 Toll House Ave., Fred. Md. 21701									
23a. BURIAL, CREMATION, REASON (SPECIFY) Burial			23b. DATE Sept. 29, 1981			23c. LOCATION Mt. Olivet Cem.			23d. LOCATION CITY OR TOWN Frederick			
24. FUNERAL DIRECTOR Smith Fadeley Keeney Basford Funeral Home 106 E. Church St., Frederick, Md. 21701						25a. DATE REC'D. BY REGISTRAR UGT 1 1981			25b. REGISTRAR'S SIGNATURE <u>Monica</u>			

005

卷之三

०८८६

200

Члены правления АО «Сибтрансгаз»

ମୋହନିବାଜାର

MODERN

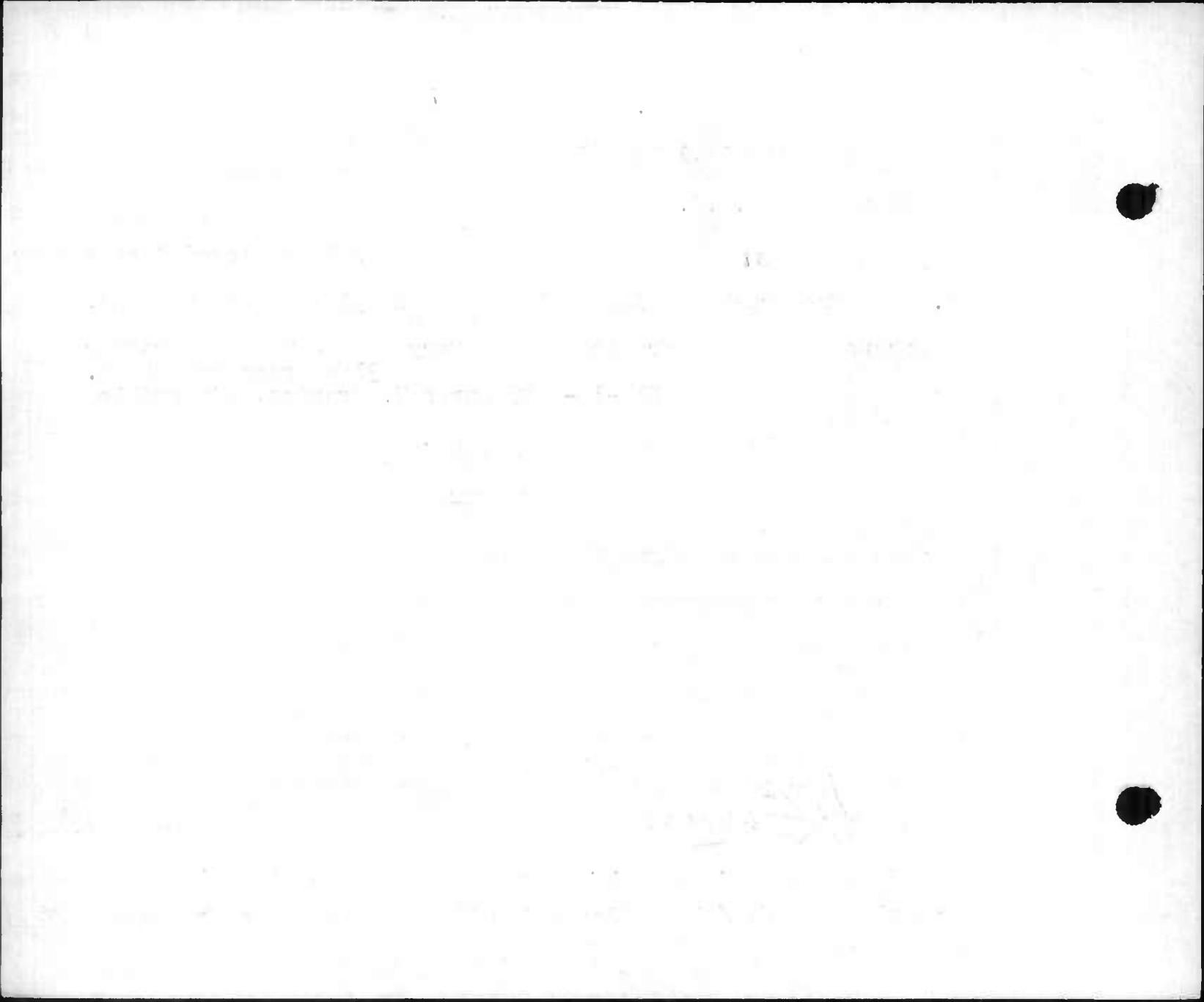
2901

24

10-15 .50 cent movie ticket job at movie theater. A lot

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NEEDED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3 RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												23961
												REG. NO.
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI. DEATH MATED			MONTH	DAY	YEAR	2b. HOUR
Raymond			H.		Frazer	<input checked="" type="checkbox"/>			9	7	19 81	M
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d. HOUR
male	white	May 12, 1912	69			<input checked="" type="checkbox"/>			9	7	19 81	8:50P
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		U.S.A.					Frederick County MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
Ijamsville		3154 Green Valley Road			self employed		Landscaper					
13a. STATE Md.		13b. COUNTY Frederick	13c. CITY OR TOWN Ijamsville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 3154 Green Valley Rd.							
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Jane LAST Frazier								
Marcus		Frazier										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT		3154 Green Valley Rd.					
No		214-18-0807			Doris V. Frazier, Ijamsville							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Subarachnoid hematoma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>ruptured berry aneurysm</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
						<input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE		<u>Hormez R. Guard</u>			TITLE (SPECIFY) M.D. Assistant		MEDICAL EXAMINER					
EXAMINER'S NAME (TYPE OR PRINT)		Hormez R. Guard, M.D.			ADDRESS 111 Penn Street, Balto., MD 21201		DATE SIGNED 9/8/81					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE Burial 9/11/81		23c. NAME OF CEMETERY OR CREMATORIAL Pleasant Hill		23d. LOCATION CITY OR TOWN Monrovia Frederick		COUNTY	STATE			
24. FUNERAL DIRECTOR NAME		ADDRESS <u>D. D. Hartzer</u>		25a. DATE REC'D. BY REGISTRAR SEP 10 1981		25b. REGISTRAR'S SIGNATURE <u>James Hartzer</u>						
DHMH-17 (VR A15 ME (5)) 15M 2/80												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 9 6 8					
										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR			
Netta			Elizabeth		Hammond	9			14	81	7:10 P.M.				
2. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White		12 5 1892			88			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			MD.					
Maryland		USA			Frederick		Frederick								
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Frederick		Frederick Memorial Hospital													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
Maryland		Frederick		Walkersville		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			301 Glade Blvd.						
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME										
Dawson		V.		Hammond	Henrietta										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
no		212-03-3080			Mrs. Charles Gearhart, Walkersville										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Acute Myo. infarction</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>72 hours</i>					
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost															
(b)															
{ DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
					YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE			
22a. I certify that (I) this hospital attended the deceased from <i>9/1/37</i> , 19 <i>81</i> , to <i>9/1/81</i> , 19 <i>81</i> , that in (my) our opinion death occurred on the date and hour and from the causes stated above, (I) we did (did not) view the body after death.															
22b. SIGNATURE <i>Netta L. Kaysman, MD</i>					DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MEDICAL DIRECTOR <input type="checkbox"/>		STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/6/81</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>Burial</i> 9/17/81		23c. NAME OF CEMETERY OR CREMATORIUM <i>Glade Cemetery</i>			23d. LOCATION CITY OR TOWN <i>Walkersville</i>			COUNTY <i>Fred.</i>		STATE <i>Md.</i>			
24. FUNERAL DIRECTOR NAME <i>G. Douglas Stauffer</i>		ADDRESS <i>Rt. 10 Fred. Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>SEP 21 1981</i>			25b. REGISTRAR'S SIGNATURE <i>James J. Martin</i>								

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	3	9	6	9				
												REG. NO.									
1 - FOR STATE REGISTRAR	I. DECEASED NAME (TYPE OR PRINT)			FIRST <u>Forrest</u>	MIDDLE <u>Forrest</u>	LAST <u>Haney</u>	2d. DATE OF DEATH	MONTH <u>Oct.</u>	DAY <u>27</u>	YEAR <u>1981</u>	2b. HOUR <u>5:00 P.M.</u>										
3. SEX	4. RACE			5. DATE OF BIRTH MONTH <u>Oct.</u>			6. AGE (IN YEARS LAST BIRTHDAY) YEAR <u>63</u>			IF UNDER 1 YEAR MONTHS <u>0</u>			IF UNDER 24 HRS HOURS <u>0</u>								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED			9. BALTIMORE CITY OR COUNTY OF DEATH <u>Frederick Co.</u>			10. CITY OR TOWN OF DEATH <u>Frederick</u>			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Frederick Memorial Hospital</u>			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Assessor</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>County</u>		
13a. STATE <u>Maryland</u>	13b. COUNTY <u>Montgomery</u>	13c. CITY OR TOWN <u>Clarksburg</u>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS <u>24910 Burnt Hill Rd.</u>															
14. FATHER'S NAME FIRST <u>Ritchie</u>	MIDDLE <u>E.</u>	LAST <u>Haney</u>	15. MOTHER'S MAIDEN NAME FIRST <u>Helen</u>			MIDDLE <u>P.</u>	LAST <u>Pearce</u>														
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT <u>Mary Esther Haney, Item 13</u>			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
No	213-12-1362																				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>respiratory arrest</u> 2050 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (b) <u>cardiac pulmonary</u> 34 DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute myocardic occlusion</u> 4 mo																					
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>											
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>May 18</u> , 19 <u>81</u> , to <u>Sept. 8</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>Sept. 6</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.												22c. DATE SIGNED <u>9/8/81</u>									
22b. SIGNATURE <u>D. A. L. Molesworth</u>												DEGREE									
22c. PHYSICIAN'S NAME (TYPE OR PRINT) <u>D. A. L. Molesworth</u>												ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>									
22d. ADDRESS <u>Clarksburg, Md.</u>																					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <u>Sept. 8, 1981</u>			23c. NAME OF CEMETERY OR CREMATORIAL <u>Clarksburg Meth.</u>			23d. LOCATION CITY OR TOWN <u>Clarksburg</u>			COUNTY <u>Montgomery</u>	STATE <u>Md.</u>									
24. FUNERAL DIRECTOR NAME <u>Olin L. Molesworth, P.A., Damascus, Md.</u>		ADDRESS			25a. DATE REC'D. BY REGISTRY <u>Sept. 8, 1981</u>			25b. SIGNATURE													

Position

Strength

Ed

80% of 100

strong

weak

ED Valuations

Strength

Weakness

Relative Strength/Weakness

Strength

Position

Weak

Strong

Strength

ED Valuations

Relative Strength/Weakness

Strength Weakness

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 8 1 2 3 9 7 0				
1 - STATE REGISTRAR			I. DECEASED NAME (TYPE OR PRINT)			LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
			MARIE H. HARTLINE						September 7 1981							
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Female			White			Month Sept. Day 22 Year 1899			81			MONTHS	DAYS	HOURS	MIN	
7a. BIRTHPLACE COUNTRY			7b. CITIZEN OF WHAT COUNTRY?			8			9 BALTIMORE CITY OR COUNTY OF DEATH			MD.				
Ohio			U. S. A.			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			Frederick							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Frederick			Homewood Retirement Center			Homemaker										
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Ohio			Tuscarawas			Dover						1604 Walnut Street				
14. FATHER'S NAME			LAST			15. MOTHER'S MAIDEN NAME										
Harvey			Huffman			Leila									Unknown	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS							
No			Unknown			Homewood Retirement Center Records										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>pneumonia</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>possible aspiration</i> (c) <i>CEREBRO-VASCULAR DISEASE c-stroke and hemiplegia</i>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>dysphagia</i>																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)										
			P.M. 19													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>6 JULY 1981</u> to <u>7 SEPTEMBER 1981</u> , that (we) last saw the deceased alive on <u>7 SEPTEMBER 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (if we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>George I. Smith Jr.</i>			DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>Sept. 7, 1981</i>							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS													
George I. Smith, Jr. M. D.			Toll House Ave, Frederick, Maryland													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL Union Grandview Cemetery			23d. LOCATION CITY OR TOWN			COUNTY		STATE		
Burial			Sept. 11, 1981						Strasburg Tuscarawas			Ohio				
23e. FUNERAL DIRECTOR <i>Smith, Adeley, Keeney & Basford Funeral Home</i>			23f. DATE REC'D. BY REGISTRAR						REC'D. 1000							
106 East Church Street, Frederick, Maryland																

100% of the time. I am not sure if this is true.

As you can see, I am not sure what to do with this information.

What would you do?

I am not sure if this is true. I am not sure if this is true.

I am not sure if this is true. I am not sure if this is true.

I am not sure if this is true. I am not sure if this is true.

I am not sure if this is true. I am not sure if this is true.

I am not sure if this is true. I am not sure if this is true.

I am not sure if this is true. I am not sure if this is true.

I am not sure if this is true. I am not sure if this is true.

I am not sure if this is true. I am not sure if this is true.

I am not sure if this is true. I am not sure if this is true.

I am not sure if this is true. I am not sure if this is true.

I am not sure if this is true. I am not sure if this is true.

I am not sure if this is true. I am not sure if this is true.

I am not sure if this is true. I am not sure if this is true.

I am not sure if this is true. I am not sure if this is true.

I am not sure if this is true. I am not sure if this is true.

I am not sure if this is true. I am not sure if this is true.

I am not sure if this is true. I am not sure if this is true.

I am not sure if this is true. I am not sure if this is true.

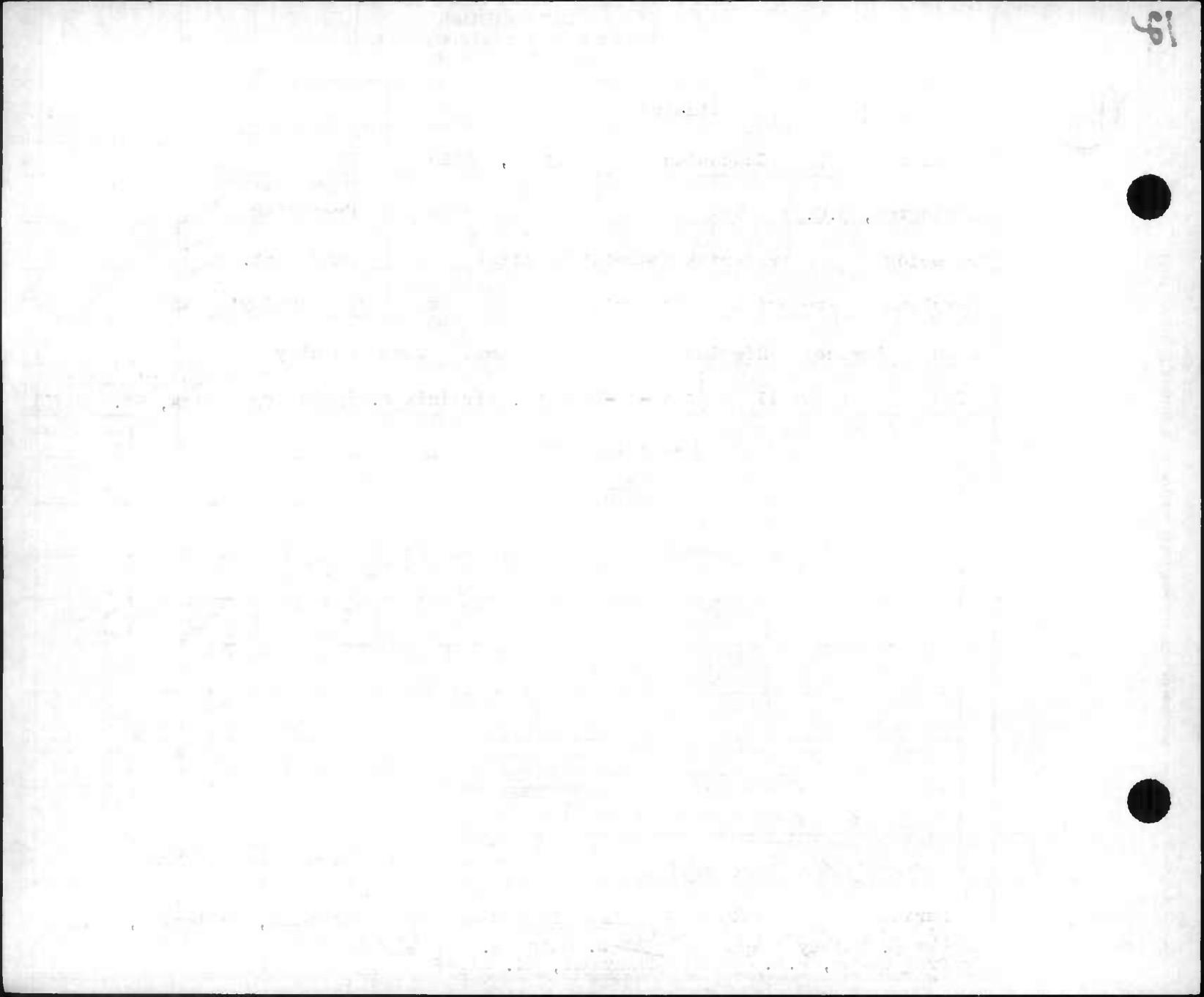
I am not sure if this is true. I am not sure if this is true.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. *Page 1*
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	2	3	9	7	1			
												REG. NO.									
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
			<i>Horace</i>			<i>Richard</i>						<i>Higgins</i>			9		5	81	5:00 PM		
3. SEX			4 RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS		8. IF UNDER 24 HRS MONTHS		9. BALTIMORE CITY OR COUNTY OF DEATH					
Male			Caucasian			Month <i>May</i> , Day <i>6</i> , Year <i>1910</i>			71							Frederick					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH												
Washington, D.C.			USA						Frederick												
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY												
Frederick			Frederick Memorial Hospital			ARMY/ Ret.			MD.												
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS									
Maryland			Frederick			Frederick						7117 Sunday's Lane									
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			MIDDLE			LAST						
John			Horace			Higgins			Emma			Jane			Ashley						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			16c. ADDRESS			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Yes			WW II			411-07-0983			M. Virginia E. Higgins			Frederick, Md.			21701						
4292																					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			(b)			DUE TO, OR AS A CONSEQUENCE OF ASCVD			(c)												
DUE TO, OR AS A CONSEQUENCE OF ASCVD																					
DUE TO, OR AS A CONSEQUENCE OF ASCVD																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																					
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?												
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)															
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE								
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE <i>L.M. Albuerne MD</i>			22c. DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED <i>9/5/81</i>												
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>L.M. Albuerne</i>			22e. ADDRESS <i>Frederick Mem. Hospital</i>																		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/9/81			23c. NAME OF CEMETERY OR CREMATORIAL Blue Ridge Cemetery			23d. LOCATION CITY OR TOWN Thurmont			COUNTY		STATE							
24. FUNERAL DIRECTOR <i>Robert E. Dailey & Son</i>			615 E. Main St.			75a. DATE DECD. BY REC. STAR <i>SEP 9 1981</i>			75b. REGISTRATION NUMBER <i>Dailey</i>												
Funeral Homes, P.A.			Thurmont, Md. 21788																		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranport permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 2 3 4 7 2					
												REG. NO.					
1 - STATE REGISTRAR			Merhl David			Kauffman			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
(TYPE OR PRINT)						Kauffman			8 25 12				9	24	81	4:25 AM	
1. DECEASED NAME			FIRST	MIDDLE													
M			Merhl														
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR			8. IF UNDER 24 HRS.		
Male			White			MONTH 8 DAY 25 YEAR 12			69			MONTHS			DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.		
Maryland			USA						Frederick								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
Frederick			Frederick Memorial Hospital						Self-employed Grocer								
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS									
Maryland			Frederick	Ladiesburg	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Ladiesburg, Md. 21759									
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST						
			Jacob	Henry	Kauffman				Daisy	Mae	Hewitt						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS								
no			215-07-8906			Mrs. Merhl Kauffman, Ladiesburg, Md.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			PART I. DEATH WAS CAUSED BY:			IMMEDIATE CAUSE (a)			Cardiogenic Shock			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
												= 12 hours					
						DUE TO, OR AS A CONSEQUENCE OF											
						(b) Atherosclerotic Cardiovascular Disease			Years								
						DUE TO, OR AS A CONSEQUENCE OF			Hypertension								
						(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a																	
Diabetes mellitus																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?								
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9/20/81 to 9/24/81, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (We) (Did) (Did not) view the body after death.						9/20 19 81 to 9/24 19 81											
22b. SIGNATURE						DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED					
C.E. Cline MD															9/24/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS														
C.E. Cline MD			804 Toll House Ave														
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION								
SPECIFY: Burial			9/26/81			Glade Cemetery			CITY OR TOWN			COUNTY			STATE		
									Walkersville			Fred.			Md.		
24. FUNERAL DIRECTOR			ADD'L						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
G. Douglas Stauffer Rt. 10 Fred. Md.									SEP 30 1981								

28 29 30 31 32 33

29 30 31 32 33 34

30 31 32 33 34 35

31 32 33 34 35 36

32 33 34 35 36 37

33 34 35 36 37 38

34 35 36 37 38 39

35 36 37 38 39 40

36 37 38 39 40 41

37 38 39 40 41 42

38 39 40 41 42 43

39 40 41 42 43 44

40 41 42 43 44 45

41 42 43 44 45 46

42 43 44 45 46 47

43 44 45 46 47 48

44 45 46 47 48 49

45 46 47 48 49 50

46 47 48 49 50 51

47 48 49 50 51 52

48 49 50 51 52 53

49 50 51 52 53 54

50 51 52 53 54 55

51 52 53 54 55 56

52 53 54 55 56 57

53 54 55 56 57 58

54 55 56 57 58 59

55 56 57 58 59 60

56 57 58 59 60 61

57 58 59 60 61 62

58 59 60 61 62 63

59 60 61 62 63 64

60 61 62 63 64 65

61 62 63 64 65 66

62 63 64 65 66 67

63 64 65 66 67 68

64 65 66 67 68 69

65 66 67 68 69 70

66 67 68 69 70 71

67 68 69 70 71 72

68 69 70 71 72 73

69 70 71 72 73 74

70 71 72 73 74 75

71 72 73 74 75 76

72 73 74 75 76 77

73 74 75 76 77 78

74 75 76 77 78 79

75 76 77 78 79 80

76 77 78 79 80 81

77 78 79 80 81 82

78 79 80 81 82 83

79 80 81 82 83 84

80 81 82 83 84 85

81 82 83 84 85 86

82 83 84 85 86 87

83 84 85 86 87 88

84 85 86 87 88 89

85 86 87 88 89 90

86 87 88 89 90 91

87 88 89 90 91 92

88 89 90 91 92 93

89 90 91 92 93 94

90 91 92 93 94 95

91 92 93 94 95 96

92 93 94 95 96 97

93 94 95 96 97 98

94 95 96 97 98 99

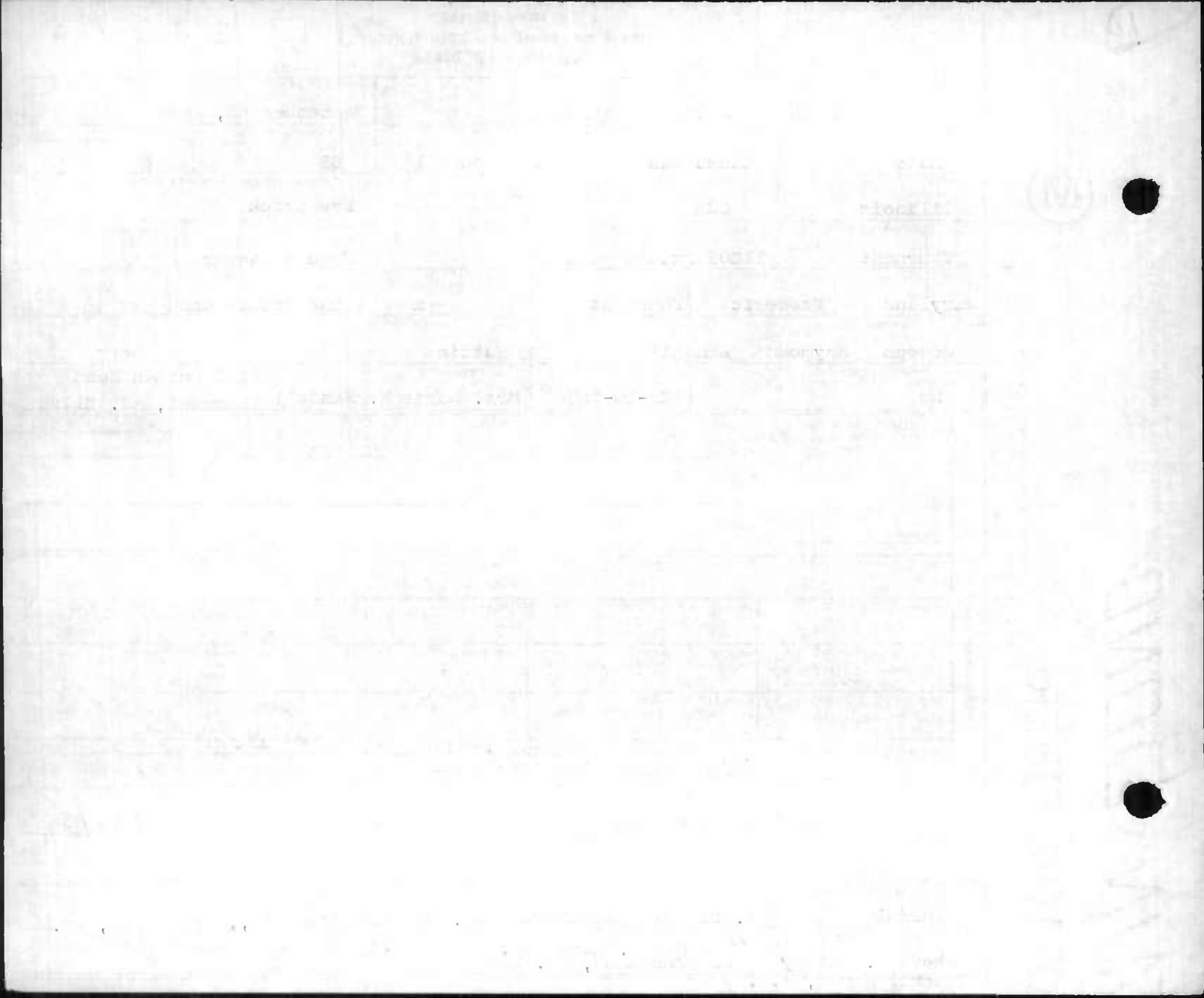
95 96 97 98 99 100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												REG. NO. 23973			
1 - FOR STATE REGISTRAR			FIRST			MIDDLE			LAST			2a DATE OF DEATH MONTH DAY YEAR		2b HOUR	
1 DECEASED NAME (TYPE OR PRINT)			DONALD			JACOB			KENDALL			September 18, 1981			
3 SEX			4 RACE			5. DATE OF BIRTH MONTH DAY YEAR						6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Male			Caucasian			8 30 13						68 YRS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Illinois			7b CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>						9 BALTIMORE CITY OR COUNTY OF DEATH Frederick		MD.	
10 CITY OR TOWN OF DEATH Thurmont			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 11208 Putman Road									12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Forest Ranger		12b. KIND OF BUSINESS OR INDUSTRY	
13a STATE Maryland			13b COUNTY Frederick			13c CITY OR TOWN Thurmont			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e STREET ADDRESS 11208 Putman Road			
14 FATHER'S NAME Joseph			MIDDLE Raymond			LAST Kendall			15. MOTHER'S MAIDEN NAME Hattie						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b SOCIAL SECURITY NO. 220-10-5806			17 INFORMANT Mrs. Marie N. Kendall			ADDRESS 11208 Putman Road						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of stomach</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
1519 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last															
DUE TO, OR AS A CONSEQUENCE OF (b)															
DUE TO, OR AS A CONSEQUENCE OF (c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from <u>many years</u> , 19 <u>81</u> , to <u>9/18/81</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>Aug.</u> , 19 <u>81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (do) (did) not view the body after death.															
22b. SIGNATURE <u>Austin Parr-J</u>			DEGREE			ATTENDING <input checked="" type="checkbox"/> MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <u>9/19/81</u>						
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9.21/81			23c. NAME OF CEMETERY OR CREMATORIAL Resthaven Mem. Gardens			23d. LOCATION CITY OR TOWN Frederick, Frederick, Md.			COUNTY		STATE	
24. FUNERAL DIRECTOR NAME Robert E. Dailey & Son			ADDRESS 815 E. Main St. Thurmont, Md. 21788						25a. DATE REC'D. BY REGISTRAR OR REGISTRAR'S SIGNATURE <u>Robert E. Dailey & Son</u>						
Funeral Homes, P.A.															



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical certificate must be completed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 9 7 4					
										REG. NO.					
1 - FOR STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR					
1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		Nov. 27, 1909		10:12 ^A				
1. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.					
Male		White		Nov. 27, 1909		71									
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)			8. CITIZEN OF WHAT COUNTRY?							9. BALTIMORE CITY OR COUNTY OF DEATH					
West Virginia			U.S.A.							Frederick					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							MD.					
Frederick			Frederick Memorial Hospital Construction												
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS						
Maryland			Frederick		Monrovia				4829A Lynn Burke Road						
14. FATHER'S NAME FIRST			MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		LAST						
James			W. Kessell				Maggie		Rodecap						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR NO UNKNOWN)			16b. SOCIAL SECURITY NO.							17. INFORMANT ADDRESS					
No			214-07-6907							Ernest C. Kessell, Jr. Cumberland, Md. 41 Memorial Ave					
18. CAUSE OF DEATH (Enter only one cause per line for a), b, and c) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
3453 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										3 days					
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Renal Acute tubular necrosis, hypertension.</i>															
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Status epilepticus, intracerebral hemorrhage</i>															
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. <i>Liver failure Coronary artery disease C.O.P.D.</i>															
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
										<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19							21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART II)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)							21f. LOCATION STREET		CITY OR TOWN	COUNTY	STATE	
22a. I certify that (I) <input type="checkbox"/> attended the deceased from <u>29 July 81</u> to <u>2 Sept 81</u> , that (I) <input type="checkbox"/> lost saw the deceased alive on <u>2 Sept 81</u> , and that in my <input type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input type="checkbox"/> did not view the body after death.															
22b. SIGNATURE			DEGREE							ATTENDING PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS									22f. DATE SIGNED			
Glen F. Brock			900 7th St #7 Frederick,									2 Sept 81			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE		23c. NAME OF CEMETERY OR CHAMBERS		23d. LOCATION CITY OR TOWN		23e. COUNTY		23f. STATE				
Burial			9/5/81		Pleasant Hill		Monrovia		Frederick		Md.				
24. FUNERAL DIRECTOR NAME			25a. DATE REC'D. BY REGISTRAR							25b. REGISTRAR'S SIGNATURE					
Olin L. Molesworth, P.A., Damascus, Md.			SEP 9 1981							James J. Martin					

11: 1 July 8 1968 - 1968-10-10

CE 2001 500000 500000 500000

1000000 600000 600000 600000

1000000 1000000 1000000 1000000

1000000 1000000 1000000 1000000

1000000 1000000 1000000 1000000

1000000 1000000 1000000 1000000

1000000 1000000 1000000 1000000

1000000 1000000 1000000 1000000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner shall be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 3 9 7 5	
												REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR	
Mary Louise Kinsey						1	9	5	81		920 P.M.		
3. SEX			RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 2 YEARS	
Female			White	MONTH	DAY	YEAR	58			MONTHS	DAYS	HOURS	MIN.
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland			U. S. A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			Frederick				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Frederick			Frederick Memorial Hospital			Nurse			Hospital				
13a. STATE			13b. COUNTY	14. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			
Maryland			Frederick	Frederick			NO			605 Biggs Avenue			
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			FIRST	MIDDLE	LAST		
William Notnagle						Julia					Kemp		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS				
No			215 18 2717			Irvin L. Kinsey, Sr.			Frederick, Maryland 605 Biggs Avenue,				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY:			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH										
IMMEDIATE CAUSE (a) <i>respiratory arrest</i>													
DUE TO, OR AS A CONSEQUENCE OF b) <i>hepatitis encephalopathy</i>			7 d										
DUE TO, OR AS A CONSEQUENCE OF c) <i>small cell carcinoma</i>			4 mo										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE		
22a. I certify that (I) (this hospital) attended the deceased from <i>Mary</i> , 19 <i>81</i> , to <i>9/5</i> , 19 <i>81</i> . That (I) (we) last saw the deceased alive on <i>9/5</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>P.S. Rosencry</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>9/6/81</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>P.S. Rosencry</i>			22e. ADDRESS <i>41 West Street</i>						Frederick, Maryland				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 8, 1981			23c. NAME OF CEMETERY OR BURIAL TOMBS Resthaven Memorial			23d. LOCATION CITY OR TOWN Frederick			STATE Md.	
24. FUNERAL DIRECTOR NAME Smith, Fadley, Keeney & Basford Funeral Home 106 East Church Street, Frederick, Maryland			25a. DATE REC'D. BY REGISTRAR Sept 10 1981			25b. REGISTRAR'S SIGNATURE <i>James J. Johnson</i>							

Digitized by srujanika@gmail.com

卷之三

卷之三

卷之三

2016-17

NO. 2200-11. *Trichomyces*

- 1 -

• 100 •



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Please return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 2 3 4 7 6				
												REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR				
John Williard Lambert SR						9/19/81						5:29 AM				
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS				
Male		White		August 28 1912			69			YRS.	MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH						
Washington, D.C.		U. S. A.								Frederick MD						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
Frederick		Frederick Memorial Hospital										Project Engineer				
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 4711 Elmer Derr Road						
14. FATHER'S NAME FIRST Charles		MIDDLE L.		LAST Lambert			15. MOTHER'S MASTERN NAME FIRST Marie			MIDDLE C.		LAST Jackson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT			ADDRESS									
Yes		W. W. # 2 577 26 0086		John Williard Lambert, Jr.												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Squamous Cell Cancer of larynx</i> 9 month													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
1889 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Vaccine</i> (c) <i>5 days</i>																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED						20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>8/22/81</i> to <i>8/22/81</i> , that (I) (we) last saw the deceased alive on <i>9/18/81</i> and that in (my) (<input checked="" type="checkbox"/>) opinion death occurred on the date and hour and from the causes stated above, (I) (<input checked="" type="checkbox"/>) (did not) view the body after death.																
22b. SIGNATURE <i>Robert S. Hughes</i>			DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>										22c. DATE SIGNED <i>9/19/81</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert S. Hughes, M.D.			22e. ADDRESS 700 Montclare Ave. Frederick, Maryland													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 22, 1981			23c. NAME OF CEMETERY OR CREMATORIUM Olivet Cemetery			23d. LOCATION CITY OR TOWN Frederick			COUNTY Frederick STATE Md.				
24. FUNERAL DIRECTOR Smith, Fadley, Keeney & Basford Funeral Home 106 East Church Street, Frederick, Maryland						SEP 22 1981			REC'D BY REGISTRAR Anne J. [Signature]			REGISTRATION SIGNATURE				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified on item 21.

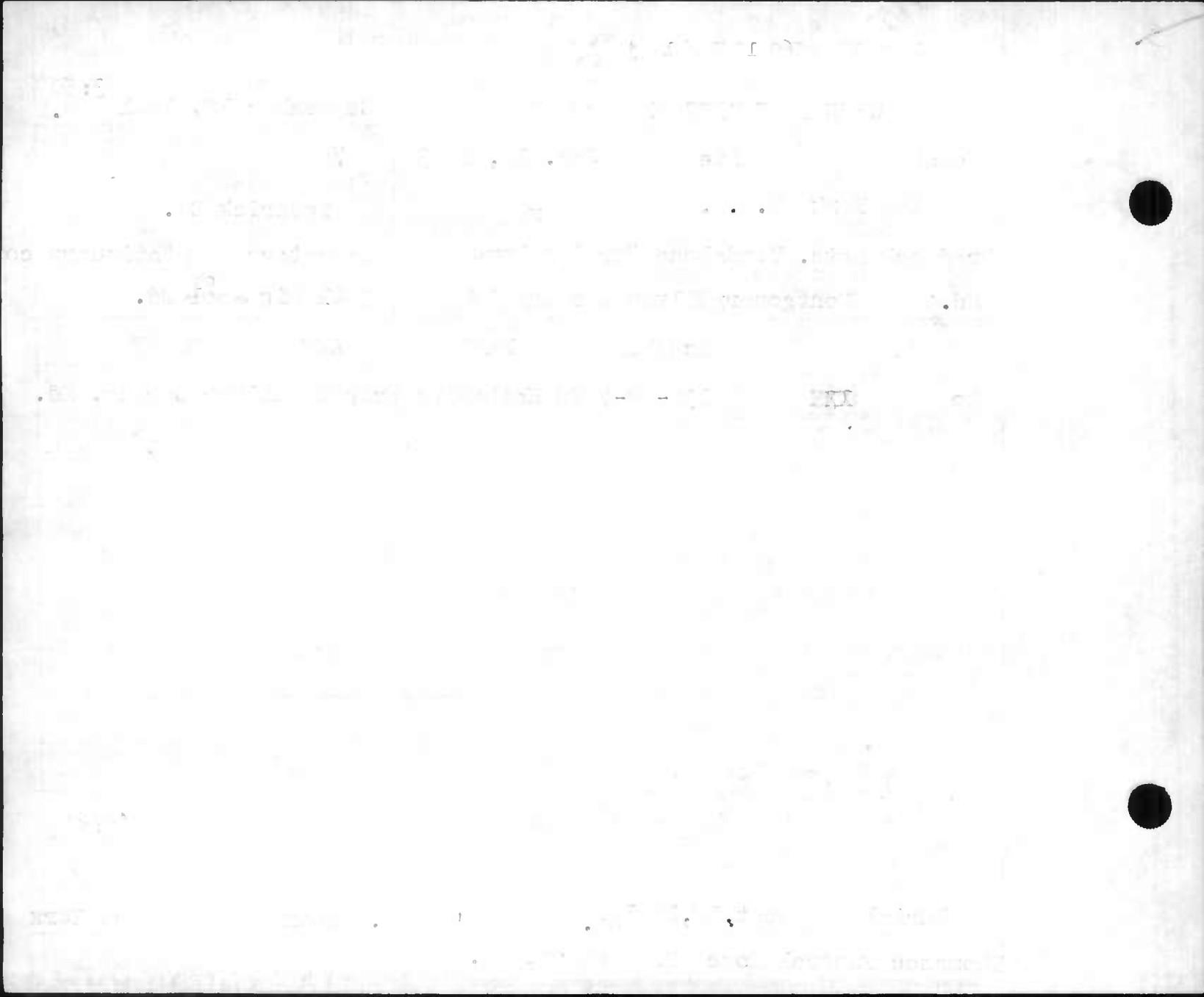
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 23 77																				
												REG. NO.																				
1. FOR - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST Mary			MIDDLE Lucinda			LAST Lind			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR											
															September 14, 1981						6:55 P.M.											
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			8. CITIZEN OF WHAT COUNTRY?			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
F.			W.			Sept. 15, 1891			89			Pennsylvania			U.S.A.			Frederick			Frederick			Center			house keeper			own home		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET ADDRESS			14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
Maryland			Frederick			Union Bridge			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			10038 Green Valley Rd.			Samuel			Clara			no			220-26-0752			Joseph S. Lind, Union Bridge, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ARTERIOSCLEROTIC CARDIO-VASCULAR DISEASE</u>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																				
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)																																
{ DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF																																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Rheumatoid arthritis; chronic rectal bleeding Etiology undetermined</u>																																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?																							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>																				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE																	
22a. I certify that (I) (this hospital) attended the deceased from <u>OCTOBER</u> , 19 <u>81</u> , to <u>OCTOBER</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>11 Sept</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												22c. DATE SIGNED <u>14 Sept. 81</u>																				
22b. SIGNATURE <u>George I. Smith Jr.</u>			DEGREE			ATTENDING PHYSICIAN			MEDICAL DIRECTOR <input checked="" type="checkbox"/>			STAFF PHYSICIAN <input type="checkbox"/>																				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>George I. Smith Jr.</u>			22e. ADDRESS <u>804 Toll House Ave. Frederick, Md.</u>																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE 1981			23c. NAME OF CEMETERY OR CREMATORIALy			23d. LOCATION CITY OR TOWN			23e. COUNTY			23f. STATE																	
Burial			Sept. 17			Haugh's			Ladiesburg Fred.			Md.																				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE																							
<u>D. D. Hartzler</u>			<u>Libertytown Md.</u>			SEP 17 1981			<u>Frances Jan Hartzer</u>																							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after the death occurs. If it cannot be done within 24 hours, it may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then erase remove carbon paper. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 8 and 13 e G 560 10/23/81 GAB FOR 1- STATE Item 13e g560 10/28/81 g REGISTRAR			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			8 2 3 9 7 8
1. DECEASED NAME (TYPE OR PRINT) GENEVIEVE VICTORIA McCABE			2a. DATE OF DEATH MONTH DAY YEAR September 12, 1981			2b. REG. NO. 263850
3 SEX Female			4 RACE White			5. DATE OF BIRTH MONTH DAY YEAR Jan. 10, 1903
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York			7b CITIZEN OF WHAT COUNTRY? U.S.A.			6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 78 YRS
10 CITY OR TOWN OF DEATH Braddock Hgts.			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Vindabona Nursing Home			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) secretary
13a. STATE Md.			13b. COUNTY Montgomery			12b. KIND OF BUSINESS OR INDUSTRY stationary co
13c. CITY OR TOWN Silver Spring			13d. STREET ADDRESS 9901 Rock Big Pool Rd.			13e. ZIP CODE 20901
14. FATHER'S NAME JAMES			15. MOTHER'S MAIDEN NAME MARY ANN DUFFY			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 139-09-7626			17. INFORMANT ADDRESS Katherine Wright Silver Spring, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) CEREBROVASCULAR ACCIDENT 4360			19. DUE TO, OR AS A CONSEQUENCE OF (b)			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last			19. DUE TO, OR AS A CONSEQUENCE OF (c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) URINARY TRACT INFECTION						
20a. DATE OF OPERATION		20b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from JULY 19 81 to SEPTEMBER 12, 1981 , that (we) lost saw the deceased alive on SEPT 11 19 81 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.						
22b. SIGNATURE Leonard Kinland		22c. DEGREE MD			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22d. DATE SIGNED 9/14/81
22e. PHYSICIAN'S NAME (TYPE OR PRINT) LEONARD KINLAND		22f. ADDRESS 320 W. POTOMAC, BRUNSWICK, MD.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 15, 1981		23c. NAME OF CEMETERY OR CREMATORIAL St. Raymond's Cem. Bronx		23d. LOCATION CITY OR TOWN New York
24. FUNERAL DIRECTOR NAME Thompson Funeral Home		25a. DATE REC'D. BY REGISTRAR Sept 1, 1981		25b. REGISTRAR'S SIGNATURE John J. Deane		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be rejoined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	1	2	3	9	7	9
										REG. NO.						
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2d. DATE OF DEATH MONTH DAY YEAR			2b. HOUR				
			Edward James McCARTHY, Sr.						Sept. 9, 1981			4:15 P.M.				
3 SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.				
Male			White			June 18, 1914			67 YRS							
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH							
Illinois			USA						Frederick Co., MD.							
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY							
Mt. Airy			4293 Molesworth Terr.			General Manager			Baking							
13a. STATE Maryland			13b. COUNTY Frederick			13c. CITY OR TOWN Mt. Airy			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 4293 Molesworth Terr.				
14. FATHER'S NAME FIRST William MIDDLE Joseph LAST McCarthy						15. MOTHER'S MAIDEN NAME FIRST Margaret MIDDLE Tolani LAST										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			ADDRESS							
No			342-05-0895			Rita B. McCarthy, Item 13										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)													APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) TERMINAL COLON CARCINOMA WITH BRAIN METASTASES													1980			
1539 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF																
(c) DUE TO, OR AS A CONSEQUENCE OF																
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 8/12/81 to 9/9/81, that (I) (we) last saw the deceased alive on 9/6/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE <i>J. Neuman</i>			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED 9/10/81							
22e. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Arthur G. Manalo, M.D.</i>			22f. ADDRESS GREEN VALLEY CENTER, MONROVIA, MD 21770													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 9/12/81			23c. NAME OF CEMETERY OR CREMATORIAL Pine Grove			23d. LOCATION CITY OR TOWN Mt. Airy Carroll Md.			COUNTY STATE				
24 FUNERAL DIRECTOR NAME <i>Olin L. Molesworth, P.A., Damascus, Md.</i>			ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP 14 1981			25b. REGISTRAR'S SIGNATURE <i>Name Jan Morris</i>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	2	3	9	8	0	
1 - FOR STATE REGISTRAR															REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST			MIDDLE			LAST			2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR		
GLENN		H.			McGREGOR						SEPT. 24		1981			9:28 A.M.		
3. SEX		4. RACE			5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White			Sept. 11, 1885						96		YRS		MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.					
Canada		U.S.A.									Frederick							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)										12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Frederick		Frederick Memorial Hospital										Partner		Hardware Store				
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Homewood Retirement Center		Frederick, Maryland								
14. FATHER'S NAME FIRST		MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST		McKenney								
William		H.			McGregor			Ida										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218 30 9493		17. INFORMANT Elizabeth McGregor, Hunter Hill Rd.		ADDRESS Hagerstown, Md.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hours										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute myocardial infarction</i>																		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last { (b) _____																		
DUE TO, OR AS A CONSEQUENCE OF (c) _____																		
DUE TO, OR AS A CONSEQUENCE OF																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 21c, PART I OR PART II)												
21d. INJURY OCCURRED AT HOME <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT HOME <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE						
22a. I certify that (if this hospital) attended the deceased from <i>9/23/81</i> to <i>9/24/81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If not in hospital) did not visit the body after death.			22b. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED Sept. 25, 1981										
22d. PHYSICIAN'S NAME Robert L. Kaufmann, M.D.			22e. ADDRESS 804 Toll House Ave. Frederick, Maryland															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE Sept. 28, 1981			23c. NAME OF CEMETERY OR CREMATORIUM Mount Olivet Cemetery		23d. LOCATION CITY OR TOWN Frederick		COUNTY Frederick		STATE Md.						
24. FUNERAL DIRECTOR Smith, Fadeley, Keeney & Basford Funeral Home 106 East Church Street, Frederick, Maryland						25a. DATE REC'D. BY REGISTRAR SEP 29 1981		25b. REGISTRAR'S SIGNATURE <i>James J. Smith</i>										

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after it is signed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the physician, it should be detached for use as the burial-travel permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 3 9 8
										REG. NO.
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Mary	Ada		MILLER	September 3,	1981			6:00 A.M.		
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	IF UNDER 24 HRS			
Female	White	Month Jan. 29, 1878 Year		103		MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH						
Maryland	U.S.A.	X		Frederick County, MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Frederick	Frederick Memorial Hospital				Homemaker				Home	
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS						
Maryland	Frederick	Frederick	X	5607 McDonald Street						
14. FATHER'S NAME	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	FIRST	MIDDLE	LAST				
William		Miller	Mary	Elizabeth		Crouse				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS							
No	None 201-16-1398	Mrs. Eunice Hagan,	5607 McDonald Street				Frederick, Md. 21701			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Clangitive Heart Failure				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 weeks					
4392	(b) Arterio-sclerotic Cardio-Vascular Disease				20 years					
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN		COUNTY	STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>March 3, 1978</u> to <u>Sept. 3, 1981</u> , that (I) (we) last saw the deceased alive on <u>Sept. 3, 1981</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.										
22b. SIGNATURE <i>Bernard O. Thomas Jr. M.D.</i>	DEGREE	ATTENDING PHYSICIAN	MEDICAL DIRECTOR	STAFF PHYSICIAN	22c. DATE SIGNED 9/4/81					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Bernard O. Thomas, Jr., M.D.	22e. ADDRESS	Professional Building, Frederick, Md. 21701								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept. 5, 1981	23c. NAME OF CEMETERY OR CREMATORIUM Haughts Cemetery	23d. LOCATION Ladiesburg, Frederick, Md.							
24. FUNERAL DIRECTOR Smith, Fadeley, Keeney, Basford Funeral Home 106 East Church Street, Frederick, Md. 21701	25a. DATE REC'D. BY REGISTRAR SEP 8 1981	25b. REGISTRAR'S SIGNATURE <i>James J. Hartman</i>								

W



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial and mental hygiene permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 7 days of death.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner should be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 2 3 4 8 2				
										REG. NO.				
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR		
RIDA			Virts	Money		Sep 9 1981						12 50 P.M.		
3. SEX			4 RACE	5. DATE OF BIRTH			6 AGE (IN YEARS AT BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS.		
Female			White	Month Day Year September 4 1894			87			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			U. S. A.						Frederick					
10 CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Frederick			Frederick Memorial Hospital			Homemaker								
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)														
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS		
Maryland			Frederick			Pt.of Rocks						1515 Ballenger Creek Rd.		
14. FATHER'S NAME			FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME			16. SOCIAL SECURITY NO.			ADDRESS		
Marshall				Virts		Bella			213 03 0817			62901 Willard L. Money, Rt. 1, Carbondale, Illinois		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
No									Congestive heart failure			1 mo.		
4140									atherosclerotic heart disease			5 yrs. t		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b)														
DUE TO, OR AS A CONSEQUENCE OF b) atherosclerotic heart disease														
DUE TO, OR AS A CONSEQUENCE OF (c)														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN	COUNTY	STATE			
22a. I certify that (I) (the physician) attended the deceased from Sep 4 1981 to Sep 9 1981, that (I) (we) last saw the deceased alive on Sep 9 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.														
22b. SIGNATURE Henry V. Chase MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED Sep 9 1981					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS											
Henry V. Chase MD			804 Toll House Ave Frederick, MD											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE XXXXX Cremation Dept. 9, 1981			23c. NAME OF CEMETERY OR CREMATORIAL Smithsburg Crematory			23d. LOCATION CITY OR TOWN Smithsburg			COUNTY Washington	STATE Md.	
24. FUNERAL DIRECTOR Smith, Adeley, Keeney & Basford Funeral Home 106 East Church Street, Frederick, Maryland						25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
						SEP 11 1981								

elastin

bony

skin

• deep connective tissue

blood vessels

basiv

cartilage

collagen

coll

Hedinger

elastin-like protein of trichilemma

c'

deep connective tissue

blood vessels

• skin

• blood vessels

• skin

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 3 9 8 3				
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR September 15, 1981							2b HOUR 10:22 A.M.				
1 DECEASED NAME (TYPE OR PRINT)		FIRST ESTHER	MIDDLE GRACE	LAST NAUGLE			6 AGE (IN YEARS LAST BIRTHDAY) 79		IF UNDER 1 YEAR MONTHS YRS DAYS 0 HOURS 0 MIN. 0					
3 SEX Female		4 RACE White		5 DATE OF BIRTH Mar. 5, 1902			7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 BALTIMORE CITY OR COUNTY OF DEATH Frederick Co.		
10 CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Frederick Memorial Hospital							12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress		12b. KIND OF BUSINESS OR INDUSTRY Shoe Co.			
13a STATE Md.		13b COUNTY Fred.		13c CITY OR TOWN Middletown			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 204 Prospect St.					
14. FATHER'S NAME FIRST JOHN		MIDDLE O'NEAL	LAST			15. MOTHER'S MAIDEN NAME FIRST CORA		MIDDLE	LAST EASTERDAY					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO UNKNOWN) No		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-20-0508							17. INFORMANT Earl Naugle		ADDRESS Middletown, Md.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory arrest.</i> 3949 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF b) <i>mitral valve disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>5 yrs.</i>														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED							20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)			21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from <u>Sept 14</u> , 19 <u>81</u> , to <u>Sept 15</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>Sept 14</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (He) (we) (they) did not view the body after death.														
22b. SIGNATURE <i>Michael S. Rudman</i>		22c. DEGREE <i>MD</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Michael S. Rudman</i>		22e. ADDRESS <i>217 W. Main St. Middletown, Md. 21765</i>				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 18, 1981			23c. NAME OF CEMETERY OR CREMATORIUM Reformed Cem.			23d. LOCATION CITY Middletown Fred. Md.		23e. STATE MD				
24. FUNERAL DIRECTOR NAME <i>Thompson Funeral Home</i>		25a. REG. NO. BY REG. DIRECTOR <i>SEP 22 1981</i>			25b. REG. DIRECTOR'S SIGNATURE <i>Janet J. Thompson</i>			25c. REG. DIRECTOR'S SIGNATURE <i>Janet J. Thompson</i>						
DHMH-1650M 1/B1 (VRA 15, 4)														

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, should be detached for use on the burial-trousser permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 2 3 7 8 4										
												REG. NO.										
1. FOR STATE REGISTRAR	1. DECEASED NAME (TYPE OR PRINT)				Russell Leroy Nusbaum				2a DATE OF DEATH				Sept. 23, 1981	2b HOUR	8 A M							
									MONTH DAY YEAR				4 22 04									
3. SEX	4 RACE				5. DATE OF BIRTH				6 AGE (IN YEARS LAST BIRTHDAY)				77 YRS	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.								
Male	White				MONTH DAY YEAR				IF UNDER 24 HRS													
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b CITIZEN OF WHAT COUNTRY?				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>				9 BALTIMORE CITY OR COUNTY OF DEATH				Frederick									
Maryland	U.S.A.				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>																	
10 CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)											12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b KIND OF BUSINESS OR INDUSTRY							
Frederick	Frederick Memorial Hospital											truck driver			cement co.							
13a STATE Maryland	13b COUNTY Carroll				13c CITY OR TOWN Union Bridge				13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				13e STREET ADDRESS 524 Key Heights Rd.									
14. FATHER'S NAME FIRST Solomon	MIDDLE Nusbaum				15. MOTHER'S MAIDEN NAME LAST Laura								LAST Wantz									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) none				17. INFORMANT				ADDRESS 524 Key Heights Rd.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 mins									
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>myocardial resp arrest or cardiac arrest</i> 4660 DUE TO, OR AS A CONSEQUENCE OF (b) <i>acute bronchitis and massive C.V.A.</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last																						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Urinary tract infection, hypertension, diabetes mellitus, gout, emphysema</i>																						
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET				CITY OR TOWN				COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <i>9/17 1981</i> to <i>9/23 1981</i> , to <i>9/23 1981</i> , that (I) (we) last saw the deceased alive on <i>9/22 1981</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																						
22b. SIGNATURE <i>William O. Miller</i>												DEGREE MD.				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 9/23/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>William O. Miller, MD</i>												22e. ADDRESS <i>KF Thomas Johnson DR Frederick, MD</i>										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE Burial 9/25/81				23c. NAME OF CEMETERY OR CREMATORIUM Mt. View Cemetery				23d. LOCATION CITY OR TOWN Union Bridge Carroll Md.													
24. FUNERAL DIRECTOR NAME <i>D. D. Shabler</i>	ADDRESS <i>Union Bridge, Md.</i>								25a. DATE REC'D. BY REGISTRAR REGISTRATION SHEET NUMBER SEP 25 1981													

M

Salisbury

no change, service denied. Leftmost column of letters, Hebrokoff

is written vertically, all other letters are rotated 90 degrees

clockwise. The letters in the first column are rotated 90 degrees

counter-clockwise. The letters in the second column are rotated 90 degrees

clockwise. The letters in the third column are rotated 90 degrees

counter-clockwise. The letters in the fourth column are rotated 90 degrees

clockwise. The letters in the fifth column are rotated 90 degrees

counter-clockwise. The letters in the sixth column are rotated 90 degrees

clockwise. The letters in the seventh column are rotated 90 degrees

counter-clockwise. The letters in the eighth column are rotated 90 degrees

clockwise. The letters in the ninth column are rotated 90 degrees

counter-clockwise. The letters in the tenth column are rotated 90 degrees

clockwise. The letters in the eleventh column are rotated 90 degrees

counter-clockwise. The letters in the twelfth column are rotated 90 degrees

clockwise. The letters in the thirteenth column are rotated 90 degrees

counter-clockwise. The letters in the fourteenth column are rotated 90 degrees

clockwise. The letters in the fifteenth column are rotated 90 degrees

counter-clockwise. The letters in the sixteenth column are rotated 90 degrees

clockwise. The letters in the seventeenth column are rotated 90 degrees

counter-clockwise. The letters in the eighteenth column are rotated 90 degrees

clockwise. The letters in the nineteenth column are rotated 90 degrees

counter-clockwise. The letters in the twentieth column are rotated 90 degrees

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be reigned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called in at once.

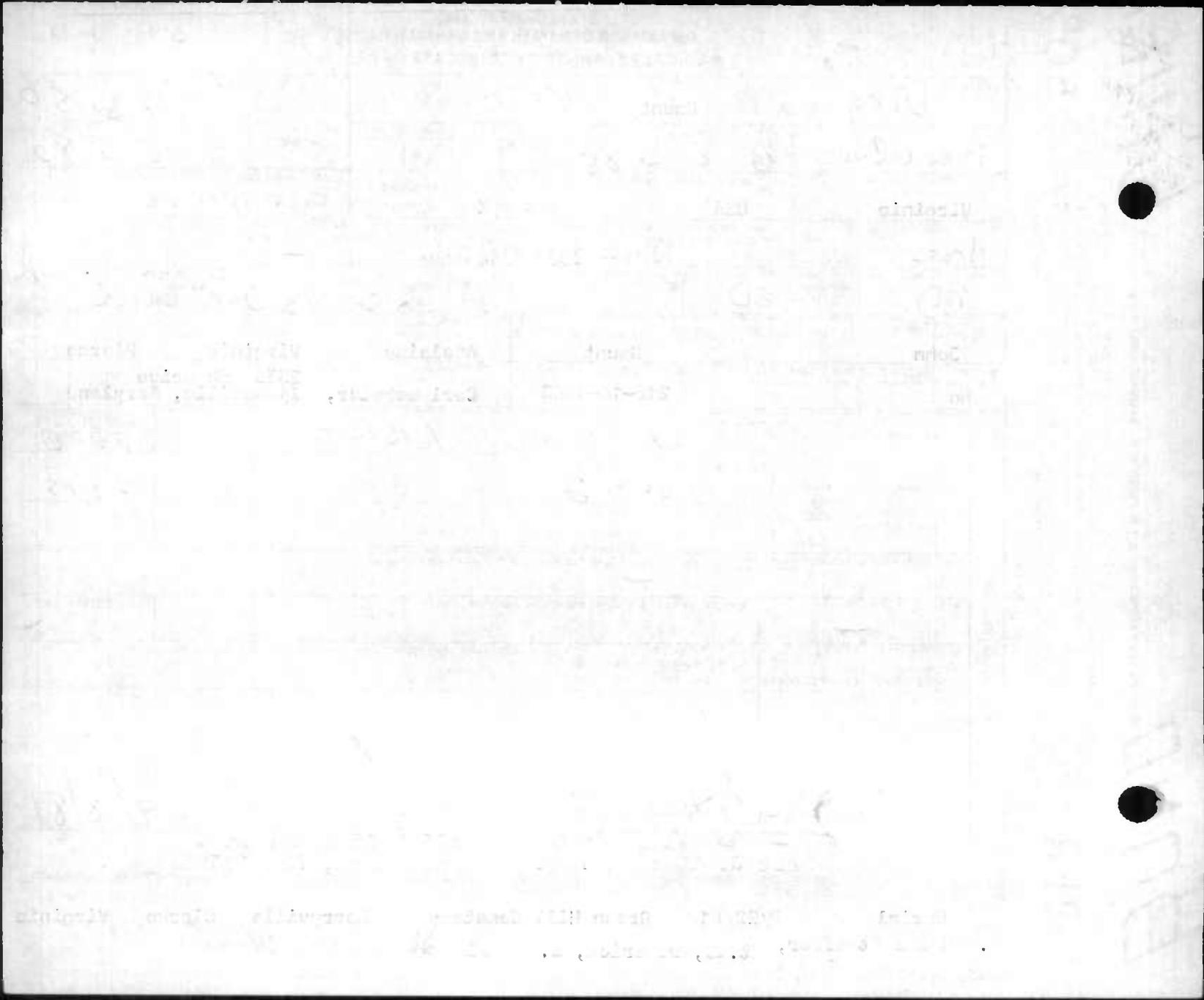
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 2 3 8 5	
												REG. NO.	
1 - STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR	
			Edith Grace OHLER						September 4, 1981			11:00a.m.	
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR IF UNDER 24 HRS	
Female			White			Nov. 10, 1895			85 yrs.			MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			MD.	
Maryland			U. S. A.						Frederick, Co.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
Emmitsburg			705 E. Main St.			Housewife							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS				
Maryland		Frederick		Emmitsburg					705 E. Main St.				
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME										
John			Grace						R. Martin				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS				
No			218-30-9694D			J. David Ohler, 705 E. Main St. Emmitsburg							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
4100 coronary thrombosis												0	
DUE TO, OR AS A CONSEQUENCE OF (b)													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, lost. (c)													
DUE TO, OR AS A CONSEQUENCE OF													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 1978, 19, to 1978, 19, the (I) (we) last saw the deceased alive on 8/15/81, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED			9/14/81	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			MD										
George L. Morningstar M.D.						22e. ADDRESS			S. Seton Ave. Emmitsburg, Md. 21827				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN			COUNTY STATE	
Burial			Sept. 7, 1981			Keysville Union			Keysville Carroll Md.				
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. DATE REC'D. BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
Skiles Funeral Home			Emmitsburg, Md. 21727			Sept. 10, 1981			George J. Skiles				

23130

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH																	
1. FOR STATE REGISTRAR											REG. NO.						
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- MATED			MONTH	DAY	YEAR						
Virginia			Gaunt	Petri	<input type="checkbox"/>	9/18/81	18	5P	M								
3. SEX		4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) YRS.	7. IF UNDER 1 YR. MONTHS DAYS	8. IF UNDER 24 HRS. HOURS MIN	2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR					
Female		Cauc	6 10 96	85			<input type="checkbox"/>	9-18	18	8P	M						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED <input checked="" type="checkbox"/>			NEVER MARRIED <input type="checkbox"/>	DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH						
Virginia			USA			<input checked="" type="checkbox"/>			<input type="checkbox"/>	<input type="checkbox"/>	Frederick						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY								
None			None 2333 Oak Drive			-			-								
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			13a. STATE MD			13b. COUNT FRED			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS 2333 OAK DRIVE		
14. FATHER'S NAME FIRST			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME FIRST			16. ADDRESS					
John						Gaunt			Adelaide			2333 Oak Drive					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
No			215-16-4863			Carl Webster, Ijamsville, Maryland			IMMED			10 yrs					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF HSND (c) DUE TO, OR AS A CONSEQUENCE OF																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?									20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY					
22a. I certify that I took charge of the remains described above, held an death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/>														
ACTUAL SIGNATURE T. F. Hickey			TITLE (SPECIFY) Deputy			MEDICAL EXAMINER 812 Toll House Ave.			ADDRESS			DATE SIGNED 9/18/81					
EXAMINER'S NAME (TYPE OR PRINT)			T. F. Hickey			Robert J. Thomas, M.D.			Frederick, Md. 21701			County			State		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORI			23d. LOCATION CITY OR TOWN								
Burial			9/22/81			Green Hill Cemetery			Perryville			Clarke			Virginia		
24. FUNERAL DIRECTOR			G. Douglas Stauffer, Rt. 10, Frederick, Md. 21701			25. DATE REC'D. BY REGISTRAR			26. REGISTRAR'S SIGNATURE								
G. Douglas Stauffer						SEP 24 1981											

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGES 1 AND 2. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BUREAU OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 M5)
15M 7/76



8 1 2 3 7 8 1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

FOR
1 - STATE
REGISTRAR

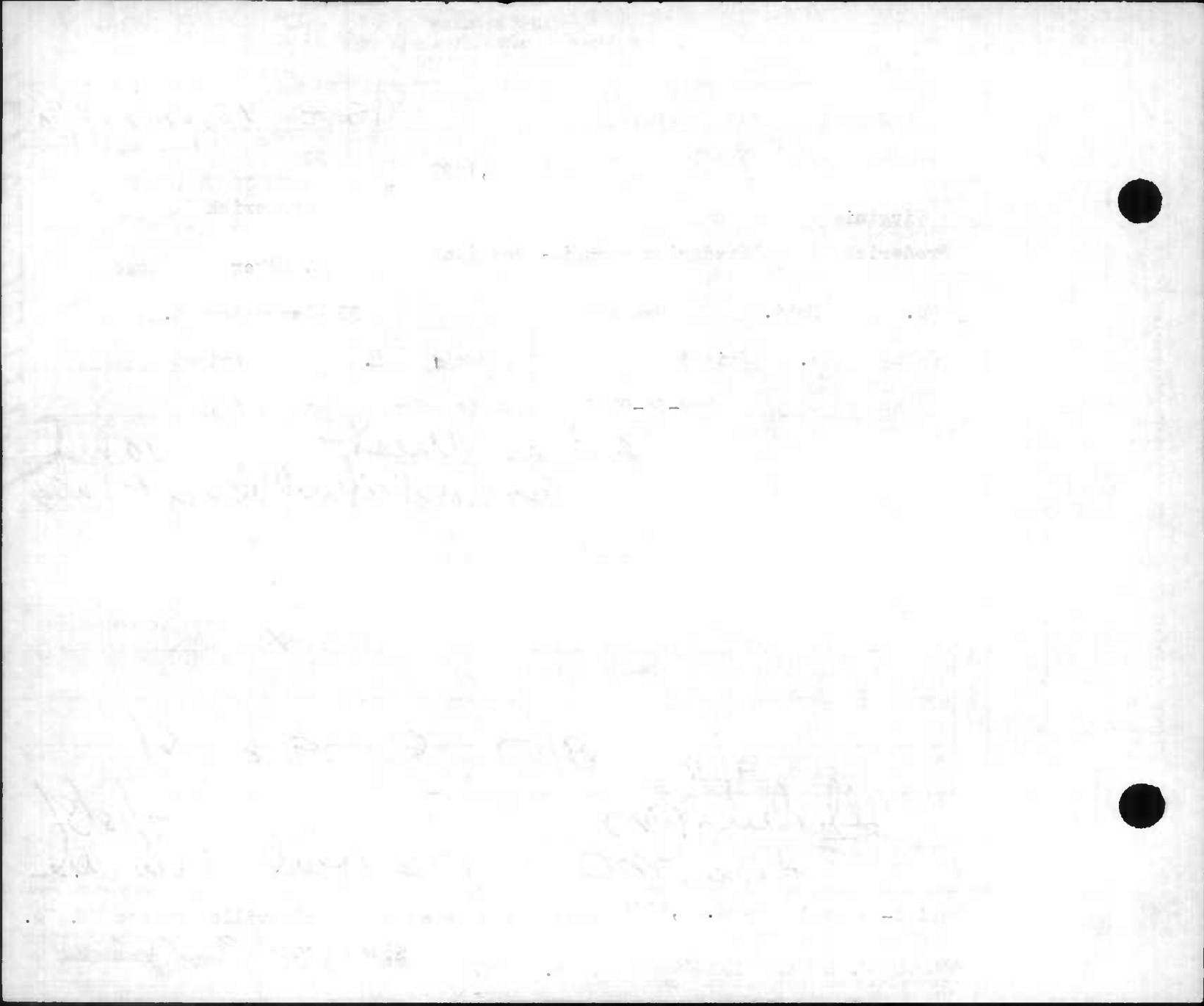
REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH	MONTH	DAY	YEAR	2b HOUR	
JENNIE GAY PRIEST						Sept. 18, 1981				7 15 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)					
FEMALE		WHITE		MONTH DAY YEAR		82		IF UNDER 1 YEAR		IF UNDER 24 HRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> X WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Virginia		USA				Frederick					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN HOSPITALITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY					
Frederick		Frederick Memorial Hospital		H. Baker		Home					
13a STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS					
Md.		Mont.		Damascus		33 Clearwater Ct.					
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME		FIRST	MIDDLE	LAST		
		John	F.	Priest			Maria	L.	Priest		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS					
no		219-54-9205		Elsie McGrady		Same as # 13					
<p>18. CAUSE OF DEATH Enter only one cause per line for 18(a), (b), and (c).</p> <p>PART 1. DEATH WAS CAUSED BY:</p> <p>5789 IMMEDIATE CAUSE (a) <i>Cardiac arrest</i> 10 my</p> <p>Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last</p> <p>DUE TO, OR AS A CONSEQUENCE OF (b) <i>Gastrointestinal bleeding 1-2 mbs</i></p> <p>DUE TO, OR AS A CONSEQUENCE OF (c)</p> <p>PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)</p>											
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
<p>22a. I certify that (I) (this hospital) attended the deceased from 9/17/81 to 9/18/81, that (I) (we) lost saw the deceased alive on 9/18/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) and (I) did not view the body after death.</p> <p>22b. SIGNATURE <i>Chesley J. Hickey</i> DEGREE</p> <p>ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/></p> <p>22c. PHYSICIAN'S NAME (TYPE OR PRINT) <i>J. Hickey MD</i> ADDRESS <i>516 Trail Fed. Rd.</i></p> <p>22d. BURIAL, CREMATION, REMOVAL <i>Burial-Removal</i> 23b. DATE <i>Sept. 21, 1981</i> 23c. NAME OF CEMETERY OR CREMATORIES <i>Valleyview Cemetery</i> 23d. LOCATION <i>Nokesville Prince Wm., Va.</i></p> <p>24. FUNERAL DIRECTOR NAME <i>FRANCIS H. BARBER</i> ADDRESS <i>LAYTONSVILLE, MD. 20879</i> 25a. DATE REC'D. BY REGISTRAR <i>SEP 21 1981</i> 25b. REGISTRAR'S SIGNATURE <i>Home of Death</i></p>											

NO HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. It must be
submitted by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be forwarded to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

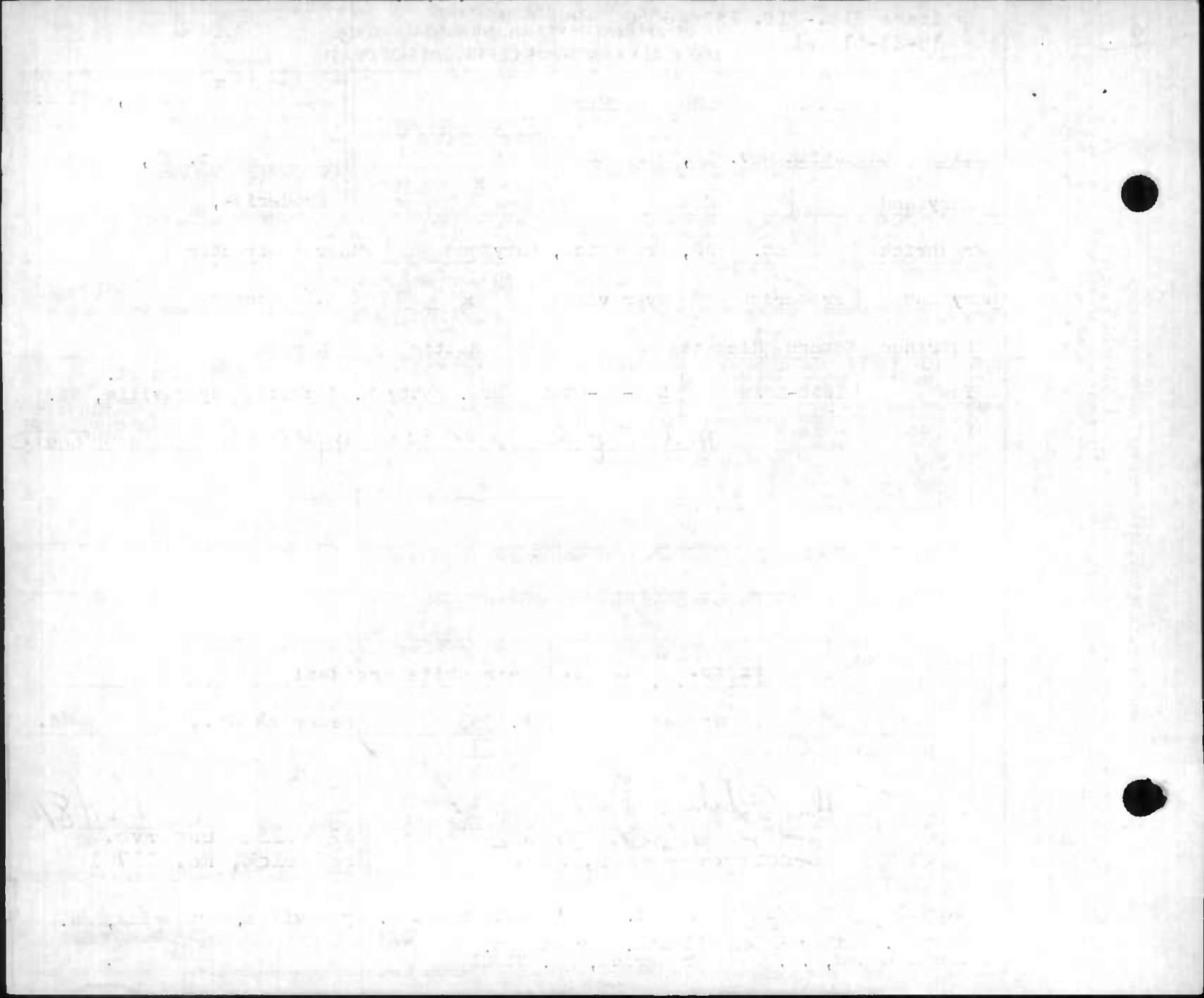
IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner may be called in to examine the deceased.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA-3 RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL/TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH FORM PA-1, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

ITEMS 21a.-21f. Film #G560 STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.	2 3 9 8 8			
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE KNOWN OF ESTI- DEATH MATED				MONTH	DAY	YEAR	2b. HOUR	
LAWRENCE EDWARD RICKETTS						<input checked="" type="checkbox"/>	Sept 21, 1981	9:31	P M					
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	MONTHS	DAYS	HOURS	MIN	2c. DATE PRONOUNCED DEAD			2d. HOUR	
Male	Caucasian	Nov. 13, 1935	45 yrs.							Sept. 21, 1981		M		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED	<input checked="" type="checkbox"/>	NEVER MARRIED	<input type="checkbox"/>	WIDOWED	<input type="checkbox"/>	DIVORCED	<input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA											Frederick, MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY		
Frederick		Rt. #355, Frederick, Maryland					Funeral Director							
13a. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Myersville		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS						
						YES <input checked="" type="checkbox"/>		NO <input type="checkbox"/>			504 Main Street			
14. FATHER'S NAME FIRST		MIDDLE		LAST		15. MOTHER'S MAIDEN NAME FIRST		MIDDLE		LAST				
Lawrence		Edward		Ricketts		Hattie				Harmon				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		(IF YES, GIVE WAR OR DATES) 1956-1958		16b. SOCIAL SECURITY NO. 214-34-0241		17. INFORMANT Mrs. Patty L. Ricketts		ADDRESS 504 Main St.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1 DEATH WAS CAUSED BY: 8199 IMMEDIATE CAUSE (a) multiple internal injuries Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ Due to, or as a consequence of (c) _____ Due to, or as a consequence of PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY?						
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. M ^o N th DAY YEAR APR 20, m. 21 1981			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Automobile accident								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Street			21f. LOCATION STREET Rt. 355			CITY OR TOWN Frederick Co.,	COUNTY	STATE Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE <i>Tony Hickey Jr.</i> TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER 812 Toll House Ave. Frederick, Md. 21701														
EXAMINER'S NAME (TYPE OR PRINT)			NAME OF CEMETERY OR CREMATORY					23d. LOCATION CITY OR TOWN St. Paul's Lutheran Cem. Myersville, Frederick, Md.						
Robert J. Thomas, M.D.														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial 9/24/81			23c. ADDRESS			COUNTY			STATE		
24. FUNERAL DIRECTOR Robert E. Dailey & Son Funeral Homes, P.A.			1201 N. Market St. Frederick, Md. 21701			23d. DATE (NOTIFICATION RECEIVED)			23e. DATE (INTERMENT MADE)					
BP														
DHHM-17 (VR A15 ME (5)) 15M 7/76														

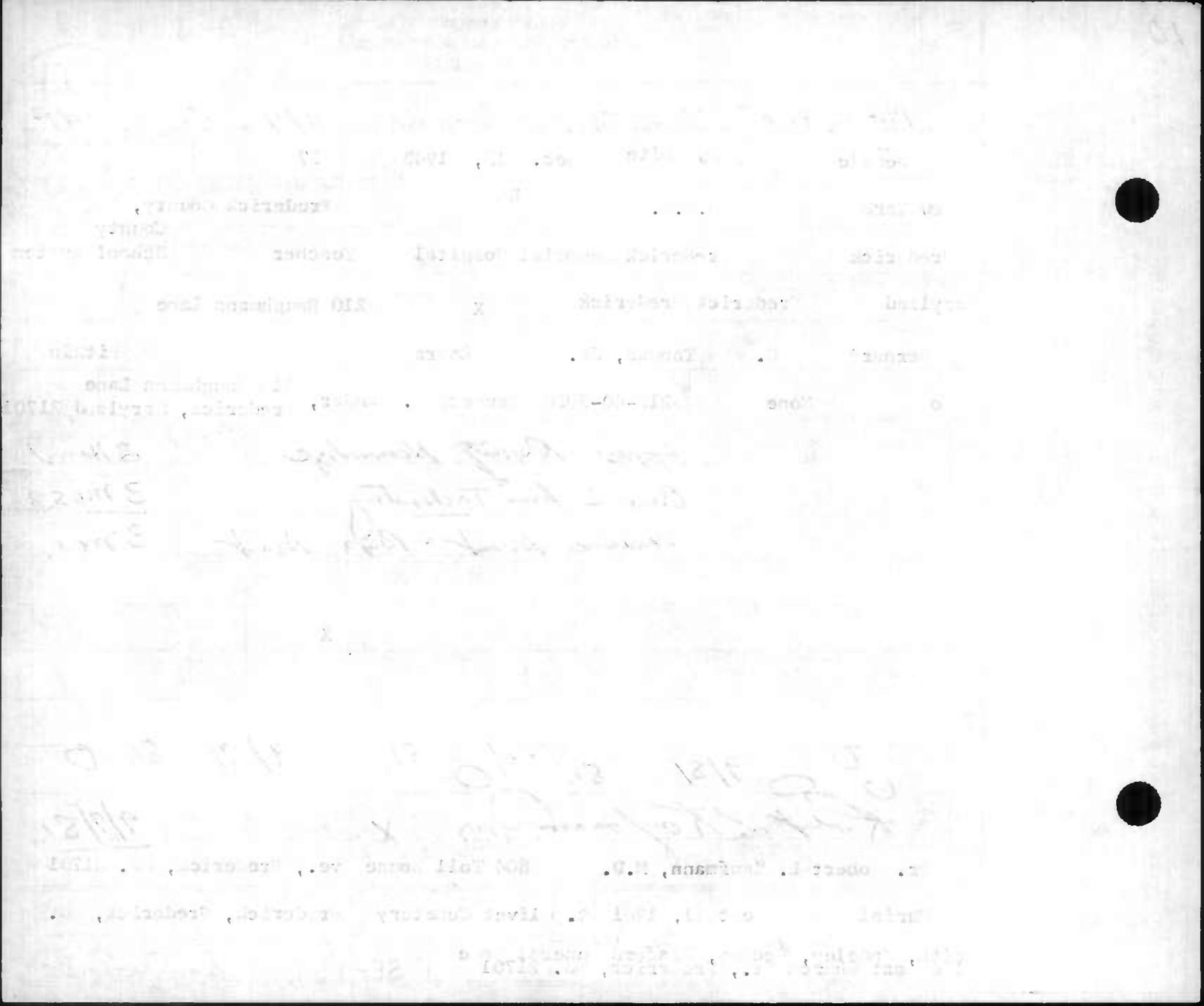


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified in writing.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8	1	2	3	4	8	9
										REG. NO.						
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)							2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR	
			<i>MARGARET Bartholow Sander</i>							9/9/81				1981	4 PM	
3 SEX			4 RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.				
Female			White		Dec. 15, 1943			37		MONTHS		DAYS				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		9. BALTIMORE CITY OR COUNTY OF DEATH						
New York			U.S.A.			WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Frederick County,		Frederick County, MD.						
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						
Frederick			Frederick Memorial Hospital							Teacher						
13d. STATE			13b. COUNTY		14. FATHER'S NAME			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS						
Maryland			Frederick		FIRST Bernard			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		210 Baughmans Lane						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR OATES)			17. INFORMANT			ADDRESS							
No			None			213-40-3030			Kenneth G. Sander, 210 Baughmans Lane Frederick, Maryland 21701							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Hyper Ruptured Hemangioma</i>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
4275 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause, if any.										3 hours						
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cessation from Tachystrogy</i>										3 mos.						
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Cardiac arrest + Respiratory arrest</i>										3 mos.						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED							20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED <small>NOT WHILE AT WORK</small>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY STATE					
22a. I certify that (1) the hospital attended the deceased from <i>5/1/81</i> to <i>9/9/81</i> , to <i>9/9/81</i> , th (1) we lost saw the deceased alive above (1) did not view the body after death.																
22b. SIGNATURE <i>Robert Kaufmann, M.D.</i> DEGREE <i>M.D.</i>										ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>9/9/81</i>				
22d. PHYSICIAN'S NAME (TYPE OR PRINT)			22e. ADDRESS													
Dr. Robert L. Kaufmann, M.D.			804 Toll House Ave., Frederick, Md. 21701													
23a. BURIAL, CREMATION, REMOVAL (SPECIAL) Burial			23b. DATE Sept 11, 1981 Mt. Olivet Cemetery			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY, TOWN							
24. FUNERAL DIRECTOR <i>Lubank C. Basford</i> Smith, Fadley Keeney Basford's Funeral Home 106 East Church St., Frederick, Md. 21701									25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>James J. Martin</i>					
									SEP 12 1981							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please sign and return by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, please remove carbon copies. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner will be summoned at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 2 3 4 9 0
1 - STATE REGISTRAR		John		Daniel		Shorrow		Shorrow		REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		Shorrow		Shorrow		DATE OF DEATH MONTH DAY YEAR		2b HOUR
John		DANIEL								9/3/81		4:50 PM
3. SEX		4. RACE		5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.
Male		White		5 29 04						77		YRS.
7a. BIRTHPLACE COUNTRY		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		X NEVER MARRIED		WIDOWED		9. BALTIMORE CITY OR COUNTY OF DEATH		MD.
Ohio		USA		<input checked="" type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>		Frederick		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
Frederick		Frederick Memorial Hospital Insurance										
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
Maryland		Frederick		Frederick		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		436 Carrollton Drive				
14. FATHER'S NAME		FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME								
John		Clarence Shorrow		Elizabeth Ann Davis								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT		ADDRESS						
no		298-10-4568		Mrs. Rhodel P. Shorrow, Fred. Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Cerebrovascular accident</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b), DUE TO, OR AS A CONSEQUENCE OF (b)												
DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Distant, mellitus - old myocardial infarction</i>												
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19c. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?				
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (the hospital) attended the deceased from <i>9/3/81</i> , 19_____, to <i>9/3/81</i> , 19_____, that (I) (we) last saw the deceased alive on <i>9/3/81</i> , 19_____, and that in (my) <i>own</i> opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Austin Pearse Jr.</i>		22c. DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <i>9/3/81</i>						
22e. PHYSICIAN'S NAME (TYPE OR PRINT)				22f. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE <i>Burial</i> 9/5/81		23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet Cem.</i>		23d. LOCATION CITY OR TOWN <i>Frederick</i>		COUNTY <i>Frederick</i>		STATE <i>Md.</i>		
24. FUNERAL DIRECTOR NAME		G. Douglas Stauffer Rt. 10 Fred. Md.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <i>Anne Jan Martin</i>						
				AUGUST SEPTEMBER OCTOBER NOVEMBER DECEMBER JANUARY FEBRUARY MARCH APRIL MAY JUNE JUNE		SEP 9 1981						

57

C8

[8]

1246

3

1

Conclusion

- 2 -

Environ Int

Geologic Geosites

五

—*so far as* —

๒๕ ที่ว่าการจังหวัด เชียงใหม่

សេចក្តីថ្លែងក្នុងប្រព័ន្ធអាសយដ្ឋាន

2158

References

Worship Center [3]

10

— 15 —

2008-09 E

卷之三

卷之三

60

TO HOSPITAL OR ATTENDING PHYSICIAN: The attending physician or attending physician

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/travel permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours at the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 2 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

23991

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	REG. NO.	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR		
Catherine Louise Sirk							9	20	81	10:55A			
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH 8	DAY 9	YEAR 23	6. AGE (IN YEARS LAST BIRTHDAY) 58	YRS	IF UNDER 1 YEAR <input type="checkbox"/>	MONTHS <input type="checkbox"/>	DAYS <input type="checkbox"/>	HOURS <input type="checkbox"/>	MIN <input type="checkbox"/>		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Frederick										
10. CITY OR TOWN OF DEATH Woodsboro	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Residence, Woodsboro, Md.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife			12b. KIND OF BUSINESS OR INDUSTRY						
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Frederick	13c. CITY OR TOWN Woodsboro	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 9924 Pine Tree Rd.							
14. FATHER'S NAME FIRST Benjamin Franklin Flockler	MIDDLE	15. MOTHER'S MAIDEN NAME Lydia	16. ADDRESS Ann Green										
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-54-2299	17. INFORMANT Louise Colbert, Woodsboro, Md.	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1991 D e h y d r a t i o n						1 Year							
DUE TO, OR AS A CONSEQUENCE OF (b) Cancer													
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).													
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that (I) (this hospital) attended the deceased from Sept 17, 1981, to Sept 20, 1981, that (I) (we) last saw the deceased alive on Sept 17, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Robert Scovner			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9/21/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robert Scovner			22e. ADDRESS 2 North 2nd Street, Woodsboro, Md.										
23a. BURIAL, CREMATION, REMOVAL Burial	23b. DATE 9/23/81	23c. NAME OF CEMETERY OR CREMATORIAL Oak Hill Cemetery			23d. LOCATION TOWN Legore	CITY OR TOWN		COUNTY		STATE			
24. FUNERAL DIRECTOR G. Douglas Stauffer, Rt. 10 Fred. Md.	ADDRESS			25a. DATE REC'D. BY REGISTRAR SEP 29 1981	25b. REGISTRAR'S SIGNATURE John Q. Miller								

REVIEW OF THE LITERATURE
INTRODUCTION

The literature on the relationship between organizational culture and performance has been growing rapidly over the past two decades. This review aims to provide an overview of the key findings and theoretical perspectives in this field.

One of the most prominent theories in this area is the Schein's model of organizational culture, which identifies three levels of culture: artifact, espoused, and underpinning. The artifact level refers to the visible elements of culture such as symbols, rituals, and stories. The espoused level refers to the explicit values and beliefs that are communicated to employees. The underpinning level refers to the underlying assumptions and deep-seated beliefs that shape the organization's behavior. According to Schein, the underpinning level is the most influential in determining organizational performance.

Another important perspective is the Hofstede's model of national culture, which identifies four dimensions: individualism, collectivism, masculinity, and femininity. These dimensions are believed to influence the way organizations are structured and managed. For example, collectivist cultures tend to emphasize group harmony and cooperation, while individualist cultures tend to emphasize personal achievement and competition.

Research has shown that there is a positive correlation between organizational culture and performance. For instance, a study by House et al. (1990) found that organizations with a strong performance-oriented culture tended to have higher levels of performance. Another study by Lirtzman et al. (1993) found that organizations with a participative culture tended to have higher levels of innovation and creativity.

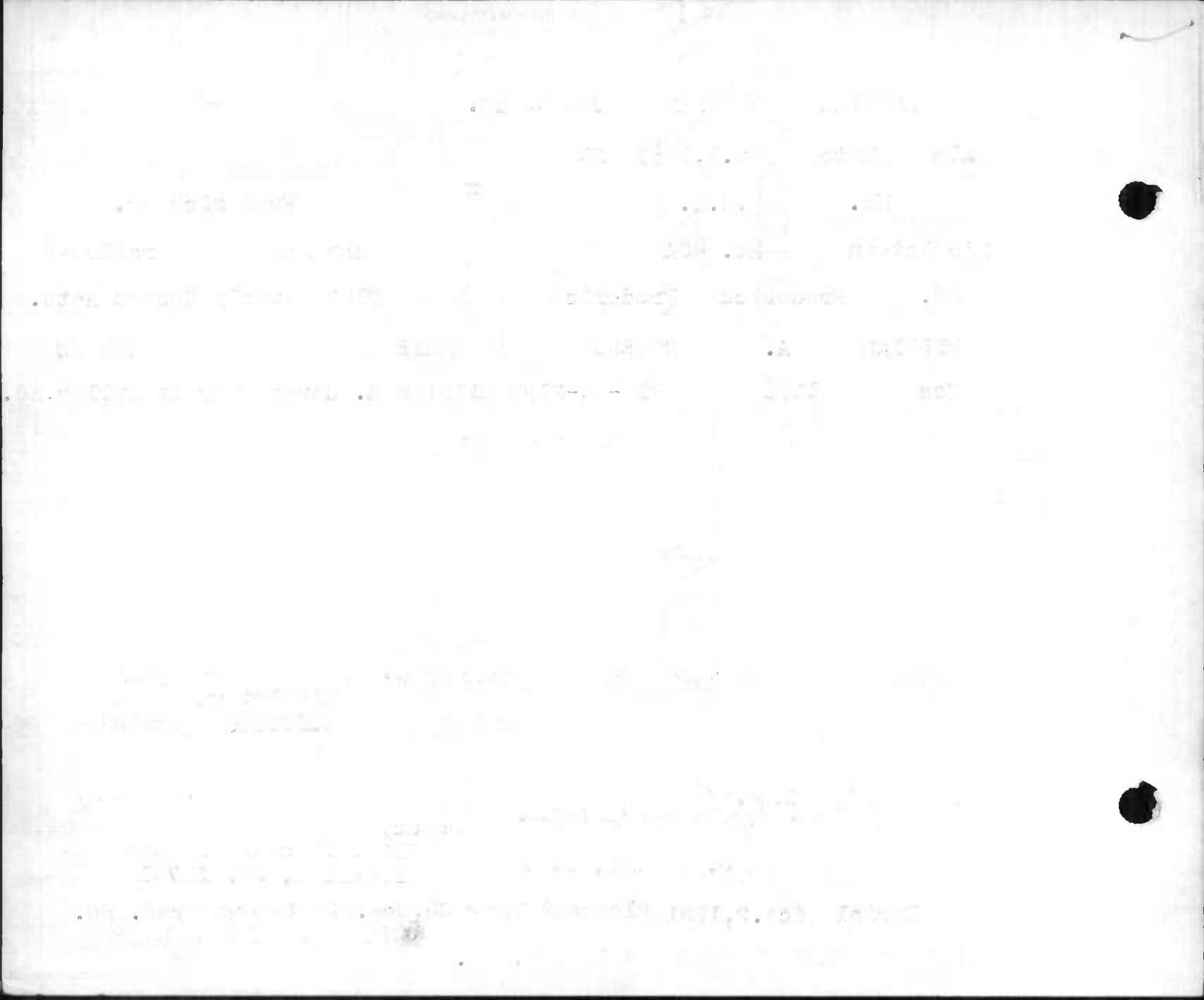
However, the relationship between culture and performance is not always straightforward. Some studies have found negative correlations or no significant relationship at all. For example, a study by House et al. (1990) found that organizations with a strong performance-oriented culture tended to have lower levels of performance. Another study by Lirtzman et al. (1993) found that organizations with a participative culture tended to have lower levels of innovation and creativity.

These mixed findings suggest that the relationship between culture and performance is complex and multifaceted. It may depend on various factors such as the industry, size, and history of the organization. It may also depend on the specific culture dimensions being considered. For example, a study by House et al. (1990) found that organizations with a strong performance-oriented culture tended to have higher levels of performance, but this was only true for organizations with a high level of collectivism. In other words, the relationship between culture and performance is moderated by the level of collectivism.

In conclusion, the literature on the relationship between organizational culture and performance is rich and varied. While there is a general trend towards a positive correlation, the specific findings can vary depending on the context and the specific culture dimensions being considered. Future research should continue to explore this complex relationship and identify the specific mechanisms through which culture influences performance.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B, GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3, RETAIN PAGE 5 FOR YOUR FILES. **TO FUNERAL DIRECTOR:** PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2 3 9 9 2		
1- STATE REGISTRAR														
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST				2a. DATE KNOWN OF ESTI. DEATH MATED			MONTH	DAY	YEAR	2b HOUR 2:45 AM
DOUGLAS WILLIAM SOWERS SR.								<input checked="" type="checkbox"/> 9 30 1981						
3. SEX	4. RACE	S. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS HOURS MIN				2c. DATE PRONOUNCED DEAD			MONTH	DAY	YEAR	2d HOUR M
Male	White	Nov. 1, 1957	23 yrs.					<input checked="" type="checkbox"/> 9 30 1981						
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH						
Md.		U.S.A.						Frederick Co. MD.						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY				
Middletown		Rt. 40A						car man		railroad				
13a. STATE Md.		13b. COUNTY Frederick		13c. CITY OR TOWN Frederick		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS P102 Waverly Garden Apts.					
14. FATHER'S NAME FIRST WILLIAM		MIDDLE A.	LAST SOWERS				15. MOTHER'S MAIDEN NAME FIRST ROXIE			MIDDLE	LAST SOWERS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 1976			16c. ADDRESS			William A. Sowers Burkittsville, Md.						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (d)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?								
									YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 2:45 AM 9 30 1981			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2) Driver of car-Struck telephone pole								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Highway			21f. LOCATION STREET Rt. 40-A			CITY OR TOWN Middletown	COUNTY Frederick	STATE Md.			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .														
ACTUAL SIGNATURE <i>Robert J. Thomas, M.D.</i> M.D. Deputy MEDICAL EXAMINER														
EXAMINER'S NAME (TYPE OR PRINT) Robert J. Thomas, M.D. ADDRESS 812 Toll House Avenue														
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE Burial Oct. 2, 1981			23c. NAME OF CEMETERY OR CREMATORIAL Pleasant View Ch. Cem. Middletown Fred. Md.			23d. LOCATION CITY OR TOWN Middletown			COUNTY Frederick	STATE Md.	
24. FUNERAL DIRECTOR NAME Thompson Funeral Home ADDRESS Middle town, Md.														
BP _____														
DHMH-17 (VR A15 ME (5)) 15M 2/80														



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 2 3 9 9 3			
1 - FOR STATE REGISTRAR			REG. NO.										
1 DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a DATE OF DEATH		MONTH	DAY	YEAR	2b HOUR			
		Walter	Raymond	SPECHT	September 15, 1981					2:45 P M			
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Male		White		July 29, 1911 ^r		70		MONTHS		DAYS			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH		MD.					
Maryland		U.S.A.				Frederick County,							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b KIND OF BUSINESS OR INDUSTRY							
Frederick		Frederick Memorial Hospital		Farmer		Farming							
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)													
13a STATE Maryland		13b COUNTY Frederick		13c CITY OR TOWN Frederick		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS					
								8212-B Edgewood Church Road					
14. FATHER'S NAME FIRST		MIDDLE	LAST	15. MOTHER'S MAIDEN NAME FIRST		MIDDLE	LAST						
Marion		B.	Specht	Effie		G.	Gaver						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17 INFORMANT		ADDRESS							
No		None		220-30-9188		Mrs. Margaret Specht, Frederick, Md. 21701							
18 CAUSE OF DEATH (Enter only one cause per line from (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										13 days			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>ASHD + hypertension</u>										4 years			
DUE TO, OR AS A CONSEQUENCE OF (c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a I certify that (I) (this hospital) attended the deceased from 7-18-81 to 9-15-81, to whom I (we) last saw the deceased alive on 9-15-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN		MEDICAL DIRECTOR		STAFF PHYSICIAN		22e. DATE SIGNED			
Dr. Rex R. Martin, M.D.										9-17-81			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b DATE		23c NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cemetery		23d LOCATION CITY OR TOWN							
Burial		Sept 18, 1981		Mt. Olivet Cemetery		Frederick, Frederick, Md.							
24 FUNERAL DIRECTOR Smith, Fadley, Keeney, Basford Funeral Home 106 East Church St., Frederick, Md. 21701		25a DATE REC'D. BY REGISTRAR		25b REGISTRAR'S SIGNATURE									
		SEP 21 1981		Rex R. Martin									

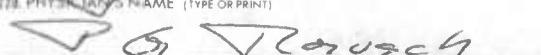
1970 1971 1972 1973 1974 1975 1976 1977 1978 1979
1980 1981 1982 1983 1984 1985 1986 1987 1988 1989
1990 1991 1992 1993 1994 1995 1996 1997 1998 1999
2000 2001 2002 2003 2004 2005 2006 2007 2008 2009
2010 2011 2012 2013 2014 2015 2016 2017 2018 2019
2020 2021 2022 2023 2024 2025 2026 2027 2028 2029
2030 2031 2032 2033 2034 2035 2036 2037 2038 2039
2040 2041 2042 2043 2044 2045 2046 2047 2048 2049
2050 2051 2052 2053 2054 2055 2056 2057 2058 2059
2060 2061 2062 2063 2064 2065 2066 2067 2068 2069
2070 2071 2072 2073 2074 2075 2076 2077 2078 2079
2080 2081 2082 2083 2084 2085 2086 2087 2088 2089
2090 2091 2092 2093 2094 2095 2096 2097 2098 2099
2100 2101 2102 2103 2104 2105 2106 2107 2108 2109
2110 2111 2112 2113 2114 2115 2116 2117 2118 2119
2120 2121 2122 2123 2124 2125 2126 2127 2128 2129
2130 2131 2132 2133 2134 2135 2136 2137 2138 2139
2140 2141 2142 2143 2144 2145 2146 2147 2148 2149
2150 2151 2152 2153 2154 2155 2156 2157 2158 2159
2160 2161 2162 2163 2164 2165 2166 2167 2168 2169
2170 2171 2172 2173 2174 2175 2176 2177 2178 2179
2180 2181 2182 2183 2184 2185 2186 2187 2188 2189
2190 2191 2192 2193 2194 2195 2196 2197 2198 2199
2200 2201 2202 2203 2204 2205 2206 2207 2208 2209
2210 2211 2212 2213 2214 2215 2216 2217 2218 2219
2220 2221 2222 2223 2224 2225 2226 2227 2228 2229
2230 2231 2232 2233 2234 2235 2236 2237 2238 2239
2240 2241 2242 2243 2244 2245 2246 2247 2248 2249
2250 2251 2252 2253 2254 2255 2256 2257 2258 2259
2260 2261 2262 2263 2264 2265 2266 2267 2268 2269
2270 2271 2272 2273 2274 2275 2276 2277 2278 2279
2280 2281 2282 2283 2284 2285 2286 2287 2288 2289
2290 2291 2292 2293 2294 2295 2296 2297 2298 2299
2200 2201 2202 2203 2204 2205 2206 2207 2208 2209
2210 2211 2212 2213 2214 2215 2216 2217 2218 2219
2220 2221 2222 2223 2224 2225 2226 2227 2228 2229
2230 2231 2232 2233 2234 2235 2236 2237 2238 2239
2240 2241 2242 2243 2244 2245 2246 2247 2248 2249
2250 2251 2252 2253 2254 2255 2256 2257 2258 2259
2260 2261 2262 2263 2264 2265 2266 2267 2268 2269
2270 2271 2272 2273 2274 2275 2276 2277 2278 2279
2280 2281 2282 2283 2284 2285 2286 2287 2288 2289
2290 2291 2292 2293 2294 2295 2296 2297 2298 2299

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial/transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 1 2 3 4 9 9 4		
										REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR			2b HOUR			
Nellie Gladys Stuhler						9-28-81			9:15 AM			
SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6 AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS		
Female		White		7 20 12			69			IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Fred			MD.		
Maryland		U.S.A.		Frederick Memorial Hospital			12a USUAL OCCUPATION Homemaker			12b KIND OF BUSINESS OR INDUSTRY		
10 CITY OR TOWN OF DEATH Frederick		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e STREET ADDRESS					
13 STATE Maryland		13b COUNTY U.S.A.		13c CITY OR TOWN Myersville								
14 FATHER'S NAME Albert		MIDDLE Eugene		LAST Hays		15. MOTHER'S MAIDEN NAME Jennie			LAST Sotttlemeyer			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN)		16b SOCIAL SECURITY NO. No		16c INFORMANT Robert E. Kline 117 Catawba Pl. Hagerstown			ADDRESS MD 21740			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		respiratory arrest										
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF (b) hypo normocytia						2d				
		DUE TO, OR AS A CONSEQUENCE OF (c) adrenal carcinoma of lung 6 my										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED					20a AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET			CITY OR TOWN		COUNTY		STATE	
22a. I certify that (I) (this hospital) attended the deceased from Mar 1981 to 9/28 1981, that (I) (we) last saw the deceased alive on 9/28 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.												
22b. SIGNATURE 		DEGREE 			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 9/29/81				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) 		22e. ADDRESS 4 West Street										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-1-81		23c. NAME OF CEMETERY OR CREMATORIAL St. Paul's Lutheran			23d. LOCATION CITY OR TOWN Myersville		COUNTY Frederick		STATE MD	
24. FUNERAL DIRECTOR Bittie - Ricketts Funeral Home		ADDRESS Myersville, MD			25a. DATE REC'D. BY REGISTRAR OCT 5 1981			25b. REGISTRAR'S SIGNATURE 				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

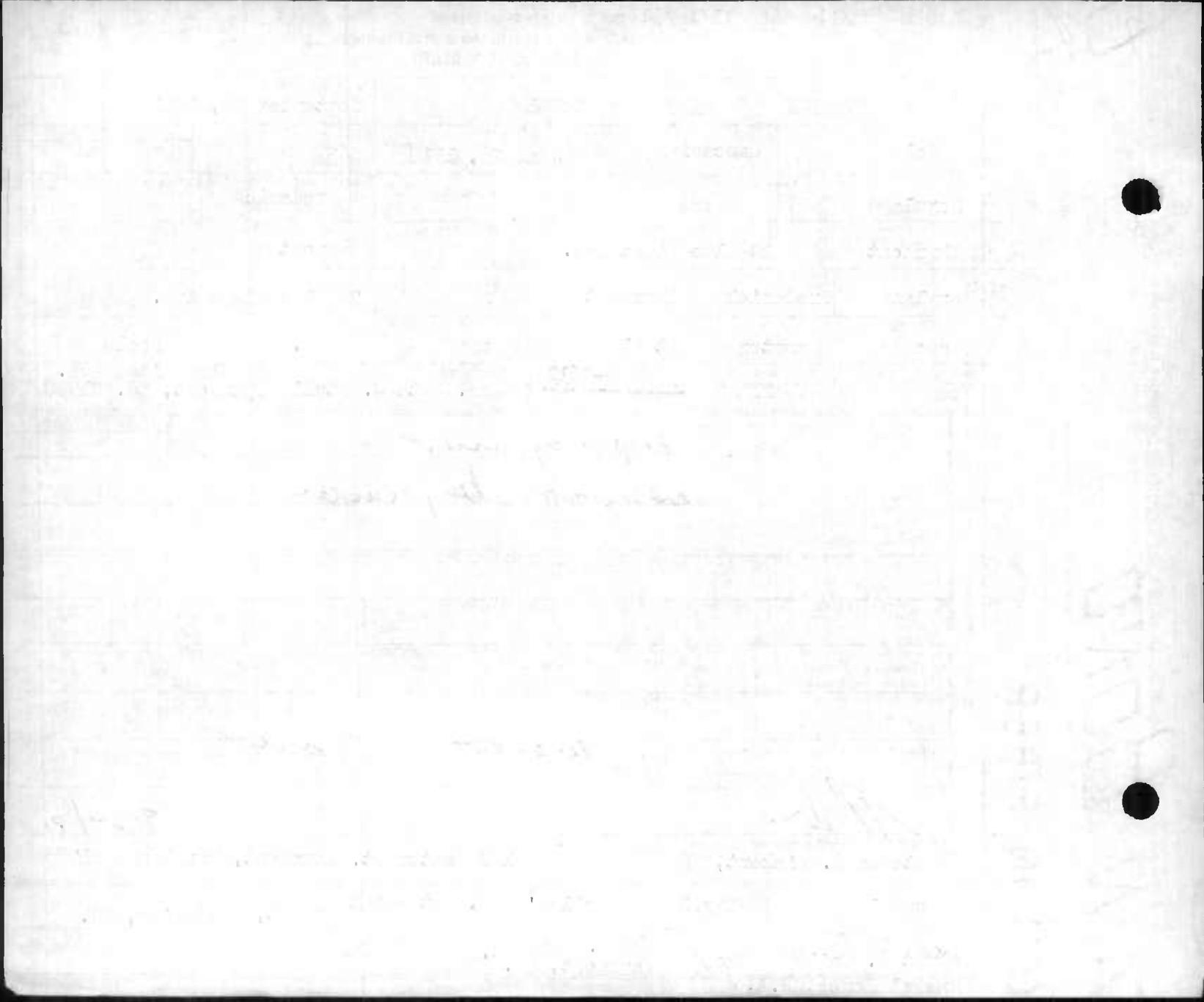
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	2	3	9	9	5					
												REG. NO.											
1 - FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)			FIRST			MIDDLE			LAST			2a. DATE OF DEATH MONTH DAY YEAR			2b. HOUR					
			<i>MARY ELIZABETH STORM</i>												<i>September 12, 1981</i>			<i>8:00 P.M.</i>					
3. SEX			4. RACE			5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR MONTHS DAYS			26. HOUR								
Female			White			<i>Nov. 4, 1890</i>			90						<i>IF UNDER 24 HRS.</i>								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH			10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Maryland			U.S.A.						Frederick County, MD.			Frederick			207 Rockwell Terrace			Housewife			- - - - -		
13a. STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS			207 Rockwell Terrace								
Maryland			Frederick			Frederick																	
14. FATHER'S NAME			MIDDLE			LAST			15. MOTHER'S MAIDEN NAME			16. ADDRESS											
William			J.			Worman			Mary			Mrs. Walter Williams, 207 Rockwell Terrace, Frederick, Maryland 21701											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive heart failure</i> 4241 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Aortic stenosis</i> (c) DUE TO, OR AS A CONSEQUENCE OF			ADDRESS			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
no			214-74-9429																				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>Cerebro-vascular disease</i>																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?														
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b, PART 1 OR PART 2)																	
			P.M. 19																				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY			STATE								
22a. I certify that (I) (this hospital) attended the deceased from <i>October 19, 67</i> , to <i>September 19, 81</i> that (I) (we) last saw the deceased alive on <i>31 August 19, 81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (did) (did not) view the body after death.																							
22b. SIGNATURE <i>George I. Smith Jr.</i>			DEGREE <i>M.D.</i>			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED <i>13 Sept 81</i>														
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Dr. George I. Smith, Jr. MD</i>			22e. ADDRESS <i>804 Toll House Ave., Frederick, Md.</i>																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>			23b. DATE <i>Sept. 15, 1981</i>			23c. NAME OF CEMETERY OR CREMATORIAL <i>Mt. Olivet Cemetery</i>			23d. LOCATION <i>Frederick Frederick Md.</i>														
24. FUNERAL DIRECTOR <i>SMITH & Fadely Keeney Basford Funeral</i>			ADDRESS <i>106 E. Church St., Frederick, Md. 21701</i>			HOLD DATE REC'D. BY REGISTRAR <i>SEP 18 1981</i>			25b. REGISTRAR'S SIGNATURE <i>Frances Jan Nathan</i>														

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

Item #16b Film G562 12/14/81 rc			STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH			2 3 4 9 6		
1. FOR STATE REGISTRAR						REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR		
STANLEY WADE STULL						September 24, 1981		
3 SEX Male		4 RACE Caucasian		5 DATE OF BIRTH June 26, 1918		6 AGE (IN YEARS LAST BIRTHDAY) 63		
						IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Frederick		
10. CITY OR TOWN OF DEATH Thurmont		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 24 Blue Ridge Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Carpenter		
13b. STATE Maryland		13b. COUNTY Frederick		13c. CITY OR TOWN Thurmont		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET ADDRESS 24 Blue Ridge Ave.								
14. FATHER'S NAME FIRST Wade			MIDDLE Hampton	LAST Stull	15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE S. LAST Poole			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes			16b. DATE OF ENLISTMENT (IF UNKNOWN, GIVE MONTH AND YEAR) WW II			17. INFORMANT ADDRESS Mrs. Ruth C. Stull 24 Blue Ridge Ave. Thurmont, Md. 21788		
18. CAUSE OF DEATH: Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) metastatic lung cancer DUE TO, OR AS A CONSEQUENCE OF (c)								
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 11-3-75 , 19 19 , to 11-3-75 , 19 19 , that (I) (we) last saw the deceased alive on 19 , 19 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.								
22b. SIGNATURE <i>Mr. Pickert</i>		DEGREE				22c. DATE SIGNED 9/24/81		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Steven A. Pickert, MD		22e. ADDRESS 100 Center St. Thurmont, Maryland 21788						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 9/27/81		23c. NAME OF CEMETERY OR CREMATORIAL Weller's Un. Methodist		23d. LOCATION CITY OR TOWN COUNTY STATE Thurmont, Frederick, Md.		
24. FUNERAL DIRECTOR <i>Robert E. Dailey & Son</i>		615 E. Main St. Thurmont, Md. 21788		25a. DATE RECD. BY REGISTRAR SEP 29 1981			25b. REGISTRAR'S SIGNATURE <i>Henry</i>	
Funeral Homes, P.A.								



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH												REG. NO. 2 3 9 9 7
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	Tresselt	2a. DATE KNOWN OF ESTI- DEATH MATED	MONTH	DAY	YEAR	2b. HOUR	
Steven Wayne						Sept. 25 1981	XX	9	22	1981	M	
3. SEX	4. RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY) 18 YRS.	IF UNDER 1 YR. MONTHS	IF UNDER 24 HRS. DAYS HOURS MIN	2c. DATE PRONOUNCED DEAD	MONTH	DAY	YEAR	2d. HOUR		
male	white	Oct. 24, 1962	18			9	22	1981	11:00	am		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED WIDOWED		NEVER MARRIED DIVORCED		9. BALTIMORE CITY OR COUNTY OF DEATH			
Maryland		U. S. A.							Frederick County MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS FOR SHIP INDUSTRY					
Frederick		Granalta Circle field/7318 Granalta Circle			Bus Boy		Inn					
13a. STATE Maryland		13b. COUNTY Frederick	13c. CITY OR TOWN Frederick	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 7318 Granalta Circle							
14. FATHER'S NAME FIRST James		MIDDLE Joseph	LAST Tresselt	15. MOTHER'S MAIDEN NAME FIRST Gaithelene	MIDDLE E.	LAST Lewis						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 215 92 9254		17. INFORMANT James J. Tresselt, 7318 Granalta Circle.	ADDRESS Frederick, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Shotgun wound of chest</u> WEAPON: SHOTGUN APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9551 Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?						
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY est. HOUR A.M. MONTH DAY YEAR 1:00 P.M. 9/22 1981			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) found shot						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, FARM, ETC.) field - rear of 7318 Granalta Circle			21f. LOCATION STREET CITY OR TOWN CITY COUNTY STATE 7318 Granalta Circle Frederick Co., MD						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> XX Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> ACTUAL SIGNATURE <u>Hormez R. Guard</u> TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER DATE SIGNED 9/22/81												
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D. ADDRESS 111 Penn Street, Balto., MD 21201												
23a. BURIAL, CREMATION, REMOVAL COPERTURE			23b. DATE Sept. 25 1981			23c. NAME OF CEMETERY OR CREMATORIAL Arlington Nat'l Cem.			23d. LOCATION CITY OR TOWN Ft. Myer			
Burial									COUNTY Arlington			
24. FUNERAL DIRECTOR Smith, Madley & Keeney & Basford Funeral Home 106 East Church Street, Frederick, Maryland									STATE Va.			
									25a. DATE REC'D. BY REGISTRAR SEP 28 1981			
									25b. REGISTRAR'S SIGNATURE <u>Hormez R. Guard</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8123998	
1. DECEASED NAME (TYPE OR PRINT)	FIRST	MIDDLE	LAST	2a DATE OF DEATH MONTH DAY YEAR September 12, 1981	2b HOUR 8:15 A.M.
3 SEX Female	4 RACE White	5 DATE OF BIRTH July 23 1914	6 AGE (IN YEARS LAST BIRTHDAY) 67	7 IF UNDER 3 YEARS MONTHS YRS. DAYS	
7a BIRTHPLACE Delaware	7b CITIZEN OF WHAT COUNTRY? U.S.A.	MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 BALTIMORE CITY OR COUNTY OF DEATH Frederick County, MD.		
10 CITY OR TOWN OF DEATH Frederick	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Frederick Memorial Hospital			12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales Lady	
13a STATE Maryland	13b COUNTY Frederick	13c CITY OR TOWN Frederick	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET ADDRESS 5708 Etzler Road	12b KIND OF BUSINESS OR INDUSTRY Dept. Stores
14 FATHER'S NAME FIRST Harvey	MIDDLE 	LAST Johnson	15 MOTHER'S MAIDEN NAME FIRST Goldie	MIDDLE 	LAST Hillyard
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no	16b SOCIAL SECURITY NO 221-01-3216	17 INFORMANT Mr. Ray W. Wahl	ADDRESS 5708 Etzler Road Frederick, Md. 21701		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Cardiac arrest APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4149 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 					
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Disease					
DUE TO, OR AS A CONSEQUENCE OF (c) 					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Hypertension					
19a DATE OF OPERATION	19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 	21f LOCATION STREET 	CITY OR TOWN 	COUNTY 	STATE
22a I certify that (I) (this hospital) attended the deceased from 1967 , 19, to 4/12/81 , 19, that (I) (we) last saw the deceased alive on 3/5/80 , 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Austin Pearson	DEGREE Jr.	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 9/14/81
22d PHYSICIAN'S NAME (TYPE OR PRINT) Dr. A. Austin Pearson, Jr.	22e ADDRESS 804 Toll House Ave., Frederick, Md.				
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE Sept. 15, 1981	23c. NAME OF CEMETERY OR CREMATORIAL Mt. Olivet Cem.	23d. LOCATION CITY OR TOWN Frederick	COUNTY Frederick	STATE Md.
24 FUNERAL DIRECTOR South End Adeley Keechey-Basford Funeral Home	ADDRESS 106 E. Church St., Frederick, Md. 21701	RECD. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE SEP 18 1981 Jan Wester			

2

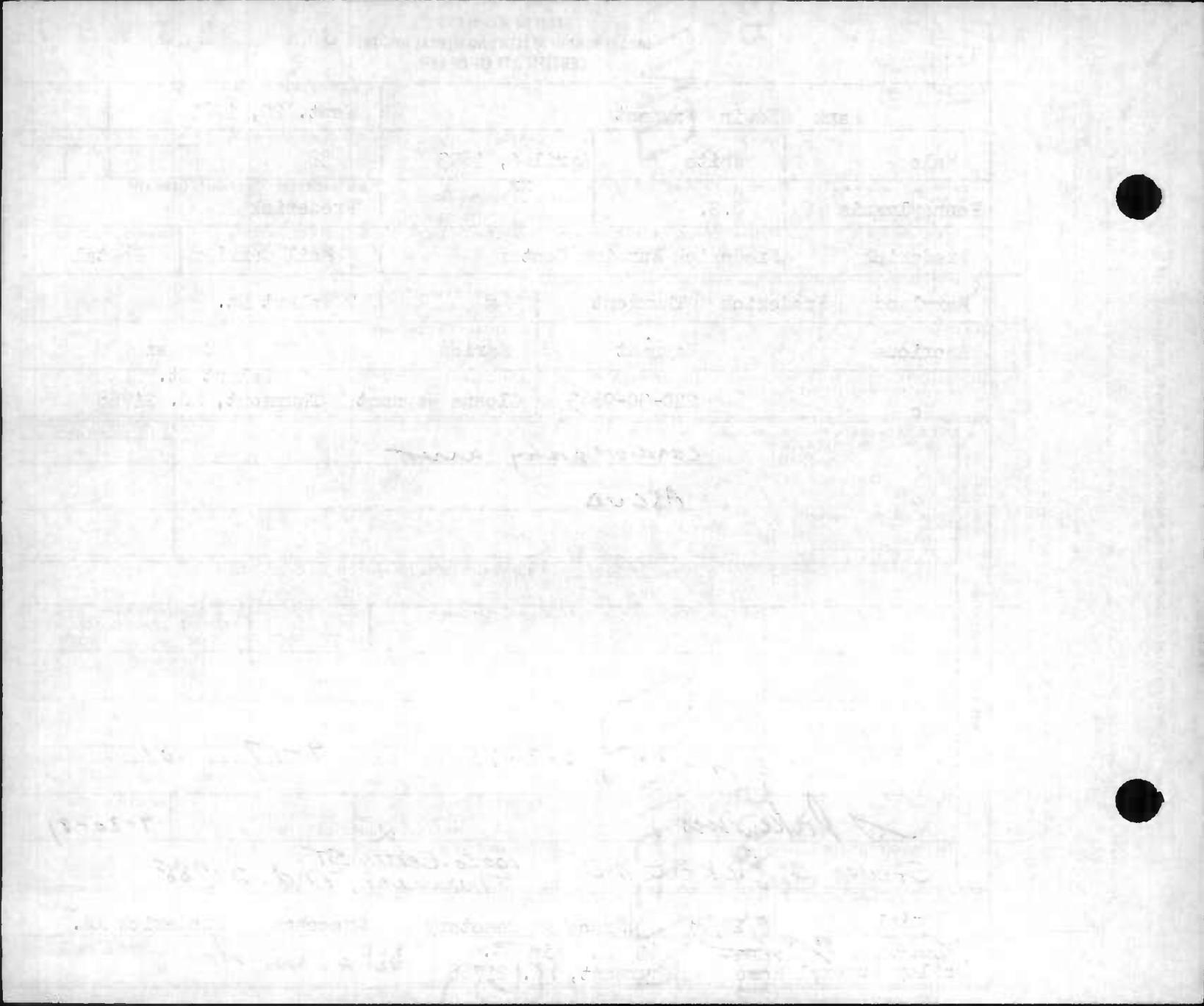
100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner/must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 1 2 3 9 9 9			
					REG. NO.			
1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH MONTH DAY YEAR	2b. HOUR		
Mark Edwin Waynant					Sept. 20, 1981			
3. SEX		4 RACE	5. DATE OF BIRTH MONTH DAY YEAR	6. AGE (IN YEARS LAST BIRTHDAY)				
Male		White	April 1, 1893	88	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED WIDOWED	NEVER MARRIED DIVORCED	9. BALTIMORE CITY OR COUNTY OF DEATH			
Pennsylvania		U.S.	<input checked="" type="checkbox"/>	<input type="checkbox"/>	Frederick			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Frederick		Frederick Nursing Center			Mail Carrier			
13. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS			
Maryland		Frederick	Thurmont		7 Walnut St.			
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME	MIDDLE	LAST	
Americus				Waynant	Marion		Bender	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT	18. ADDRESS			
No		220-30-9843		Glenna Waynant	7 Walnut St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART I. DEATH WAS CAUSED BY:								
IMMEDIATE CAUSE (a)		cardiorespiratory arrest						
4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost		DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD						
		DUE TO, OR AS A CONSEQUENCE OF (c)						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN	COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 6-9-78, 19_____, to 9-17, 1981, that (I) (we) last saw the deceased alive on 9-17, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE		DEGREE						22c. DATE SIGNED
Steven A. Pickett MD								9-20-81
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION CITY OR TOWN		23e. COUNTY STATE	
Burial		9/22/81	Graceham Cemetery		Graceham		Frederick Md.	
24. FUNERAL DIRECTOR Dailey Funeral Home		615 E. Main St.		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
		Thurmont, Md. 21788		SEP 28 1981		John P. Pickens		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8 1 2 4 0 0 0		
												REG. NO.		
1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST			2a. DATE OF DEATH			MONTH	DAY	YEAR	2b. HOUR
Ross Edward WETZEL								September 13, 1981						8:00p.m.
3. SEX			4 RACE	5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male			White	Month Day Year February 28, 1902			79			MONTHS	DAYS	HOURS	MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland			U. S. A.						Frederick County MD					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY					
Emmitsburg			16916B Annandale Rd. Emmitsburg			Laborer								
13a. STATE			13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS						
Maryland			Frederick	Emmitsburg				R. D. # 1						
14. FATHER'S NAME			FIRST	MIDDLE	LAST			15. MOTHER'S MAIDEN NAME						
Edward					Wetzel			Lucy			Tressler			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			18. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
No			213-18-0792			Emmitsburg, Md. 21727			~5 weeks					
Glenna Wollard 16916B Annandale Rd.														
18. CAUSE OF DEATH (Enter only one cause per line for 1a, 1b, and 1c.) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			DUE TO, OR AS A CONSEQUENCE OF (b)			Cerebrovascular Accident			Cerebrovascular Insufficiency			~5 weeks		
4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b).			DUE TO, OR AS A CONSEQUENCE OF (c)									years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?					
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET			CITY OR TOWN			COUNTY		STATE
22a. I certify that (I) (this hospital) attended the deceased from _____ 19_____, to _____ 19_____, that (I) (we) last saw the deceased alive on _____ 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death.														
22b. SIGNATURE			22c. DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22d. DATE SIGNED					
Alan Carroll M. D.												Sept. 13, 1981		
22e. PHYSICIAN'S NAME (TYPE OR PRINT)			22f. ADDRESS			S. Seton Ave. Emmitsburg, Md. 21727								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION CITY OR TOWN			COUNTY		STATE
Burial			16 Sept 81			Emmitsburg Memorial			Emmitsburg			Frederick		Md.
24. FUNERAL DIRECTOR NAME			ADDRESS			25a. FILED BY REGISTRAR			25b. REGULAR SIGNATURE					
Skiles Funeral Home			Emmitsburg, Md. 21727			SET 17 1981								

001 100 E 2000 2000 2000 2000 2000

200 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

2000 2000 2000 2000 2000 2000 2000

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

24001

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST	MIDDLE	LAST	2a. DATE OF DEATH	MONTH	DAY	YEAR	2b. HOUR
-------------------------------------	--	--	-------	--------	------	-------------------	-------	-----	------	----------

ANNA L. WHITMORE

3. SEX	4. RACE	5. DATE OF BIRTH	MONTH	DAY	YEAR	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.
--------	---------	------------------	-------	-----	------	---------------------------------	---------------------------	--------------------------	-------	------

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH
---	------------------------------	---	--------------------------------------

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY
---------------------------	---	--	--------------------------------------

13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS
------------	-------------	-------------------	---	---------------------

14. FATHER'S NAME	FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME
-------------------	-------	--------	------	--------------------------

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
---	--------------------------	---------------	---------

16c. (IF YES, GIVE WAR OR DATES)	16d. ?	16e. Linda Bisaccia	Thurmont, Md.
----------------------------------	--------	---------------------	---------------

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CARDIO-VASCULAR DISEASE

4292

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) SEVERE ARTERIOSCLEROTIC CARDIOPATHIC DISEASE

{ DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

DIABETES

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
------------------------	--	--	--

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)
--	--	---

21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
---	--	-------------------------	--------------	--------	-------

22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>JULY</u> , 19 <u>80</u> , to <u>September</u> , 19 <u>81</u> , that <input checked="" type="checkbox"/> (s)he last saw the deceased alive on <u>14 September 19 81</u> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.
--

22b. SIGNATURE	DEGREE	ATTENDING PHYSICIAN <input checked="" type="checkbox"/>	MEDICAL DIRECTOR <input type="checkbox"/>	STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED
----------------	--------	--	--	---	------------------

22d. PHYSICIAN'S NAME (TYPE OR PRINT)	22e. ADDRESS
---------------------------------------	--------------

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL	23d. LOCATION CITY OR TOWN
--	-----------	--------------------------------------	-------------------------------

24. FUNERAL DIRECTOR	ADDRESS	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
----------------------	---------	-------------------------------	----------------------------

BP _____

DHMH - 16 50M 1/81
(VRA 15, 4)

38

Wet or dry

Brilliant colors

Houseboat

AZU

Teeth white

greenish-yellow

Darkish green

purple-red

dark reddish brown

yellow

Dark reddish

yellow

yellow

yellow

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH												8	1	24	002
												REG. NO.			
1. FOR STATE REGISTRAR		Carl		Douglas											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST									
CARL						Whitney									
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7a. DATE OF DEATH		MONTH		DAY	YEAR	2b. HOUR	
White Male		White		2 24 1892		89		9 26 81		9		26	81	2:15 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8		MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
Iowa		USA				WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Frederick							
MD															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN HOSPITAL, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Frederick		Frederick Memorial Hospital		Fed. Govt.											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS							
Maryland		Frederick		Frederick		YES <input checked="" type="checkbox"/>		1352 Taney Ave.							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME													
John Lewis		Anna													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES NO UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
yes		224-60-0480		Mrs. Whitney, Frederick, Md.											
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac Arrest</i>												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>minutes</i>			
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Lung Cancer</i>												<i>? months</i>			
DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		YES <input type="checkbox"/> NO <input type="checkbox"/>									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE					
22a. I certify that (s) (he) (she) hospital attended the deceased from saw the deceased alive on above. (I (we) (he) (she) did not visit the body after death.)		19 81		19 81		9/26		19 81		9/26					
22b. SIGNATURE <i>C.E. Cline MD</i>		22c. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED 9/26/81											
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>C.E. Cline MD</i>		22e. ADDRESS 804 Toll House Ave													
23a. BURIAL, CREMATION, REMOVAL SPECIES Burial		23b. DATE 9/30/81		23c. NAME OF CEMETERY OR CREMATORIAL Resthaven Mem. Gar. Frederick Fred. Md.		23d. LOCATION									
24. FUNERAL DIRECTOR G. Douglas Stauffer Rt. 10 Frd. Md.				25a. DATE REC'D. BY REGISTRAR OCT 1 1981		25b. REGISTRAR'S SIGNATURE <i>James J. Martin</i>									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 81 24003								
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)			FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR		
		ELsie NAOMI YOUNKINS									Sept. 18, 1981					8:30 M		
3. SEX		4. RACE			5. DATE OF BIRTH						6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		White			Month Day Year			May 10, 1903			78		YRS.		MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?			8			MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		Frederick Co. MD.					
Md.		U.S.A.			8						Frederick Co.							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)						12b. KIND OF BUSINESS OR INDUSTRY							
Frederick		Frederick Nursing Center			Housewife						Own Home							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS									
Md.		Fred.		Middletown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Mt. Church Rd.									
14. FATHER'S NAME		FIRST	MIDDLE	LAST	15. MOTHER'S MAIDEN NAME													
		EDGAR	O.	ROHRBACK	ESTA						FINK							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS										
NO		NONE			Charles Younkins			Middletown, Md.										
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Natural cause</i> <i>4590</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE MATERIAL BETWEEN ONSET AND DEATH <i>Today 20 yrs.</i>								
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Fredericks Starve</i> { DUE TO, OR AS A CONSEQUENCE OF (c)																		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																		
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?										
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			YES <input type="checkbox"/> NO <input type="checkbox"/>			YES <input type="checkbox"/> NO <input type="checkbox"/>							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET <i>824</i> CITY OR TOWN <i>649-9-18</i> COUNTY <i>81</i> STATE													
22a. I certify that (I) (this hospital) attended the deceased from <i>9/18/81</i> to <i>9/18/81</i> , 19 <i>81</i> , that (I) (we) lost saw the deceased alive on <i>9/18/81</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										27. DATE SIGNED <i>9/18/81</i>								
22b. SIGNATURE <i>J. Byron Kao MD</i>																		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			ATTENDING <input checked="" type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> STAFF DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>													
C.T. BYRON KAO		<i>Bowie Ch. Cem. Locust Valley</i>																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE			23c. NAME OF CEMETERY OR CREMATORIUM			23d. LOCATION CITY OR TOWN <i>Middletown</i> COUNTY <i>Fred. Md.</i> STATE										
Burial		Sept. 22, 1981			Bible Ch. Cem. Locust Valley													
24. FUNERAL DIRECTOR NAME		ADDRESS			25. DATE REC'D. BY REGISTRAR			25. REGISTRAR'S SIGNATURE										
Thompson Funeral Home		Middletown,			SEP 24 1981			<i>Home J. Thompson</i>										

1000' 2000' 3000'

2000' 1500' 1000' 500'

1000'

1000' 500' 200' 100' 50'

AT&T CABLES

AT&T CABLES

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.			
1 - STATE REGISTRAR			2a DATE OF DEATH MONTH DAY YEAR							2b HOUR p.m.			
1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			September 17, 1981 8:30 p.m.							
THOMAS HORACE ZIMMERMAN													
1. SEX		4 RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male		White		Oct. 19, 1904			76		YRS.		MONTHS DAYS HOURS MIN.		
7b BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH		MD.				
Maryland		U. S. A.					Frederick County						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)							12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				
Brunswick		420 A Street							Packer				
13a STATE Maryland		13b COUNTY Frederick		13c CITY OR TOWN Brunswick			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET ADDRESS 420 "A" Street				
14. FATHER'S NAME S.		MIDDLE Joseph		LAST Zimmerman			15. MOTHER'S MAIDEN NAME Florence		16. LAST NAME McDonald				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b SOCIAL SECURITY NO. No None 214 10 1797			17. INFORMANT Mrs. Maxine Zimmerman, Brunswick, Md. 21716		ADDRESS 420 "A" Street				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b). (c) DUE TO, OR AS A CONSEQUENCE OF (c) PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) DIABETES MELLITUS												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 15 years	
19a. MEDICAL CERTIFICATION		19b. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET			CITY OR TOWN		COUNTY		STATE		
22a. I certify that <input type="checkbox"/> (this hospital) attended the deceased from APRIL , 19 81 , to SEPT. 17 , 19 81 , that <input type="checkbox"/> (we) last saw the deceased alive on July 17 , 19 81 , and that in <input type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) did <input type="checkbox"/> (did not) view the body after death.													
22b. SIGNATURE Leonard Kinland		22c. DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		STAFF		22d. DATE SIGNED 9/21/81					
22e. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Leonard Kinland, M.D.		22e. ADDRESS 320 W POTOMAC, BRUNSWICK, MD.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Sept. 22, 1981		23c. NAME OF CEMETERY OR CREMATORIUM Mt. Olivet Cemetery			23d. LOCATION CITY OR TOWN Frederick		COUNTY Frederick		STATE Md.		
24. FUNERAL DIRECTOR Smith, Fadely, Keeney & Basford Funeral Home 106 East Church Street, Frederick, Maryland		25a. DATE REC'D. BY REGISTRAR SEP 24 1981		25b. REGISTRAR'S SIGNATURE James J. Hartman									

